The Regulation and Quality Improvement Authority

AGENDA

RQIA Authority Meeting
Virtual Meeting via Zoom
Thursday 9 September 2021, 11.15am

PUBLIC SESSION

	Item	Paper Ref	
1	Welcome and Apologies		**11.15am**
2	Minutes of the meeting of the Authority held on 12 August 2021 and matters arising	Min/Aug21/ public	**11.20am APPROVE**
3	Declaration of Interests		**11.25am**
4	Members Activity Report **Interim Chair**	B/09/21	**11.30am NOTE**
	STRATEGIC ISSUES		
5	Winter and Services Pressures Resilience Plan 2021/2022 **Chief Executive**	F/09/21	**11.35am APPROVE**
6	Investors in People (IiP) Re-Accreditation **Chief Executive**		**12.00pm APPROVE**
7	Finance Performance Report (Month 4) **Lesley Mitchell, Associate HSC Leadership Centre**	G/09/21	**12.10pm NOTE**
8	Part II / Second Opinion Appointed Doctors (SAODs) Panel Update **Acting Director of Improvement**	H/09/21	**12.20pm NOTE**
9	Audit and Risk Assurance Committee **Committee Chairman** • Verbal Update: Meeting of 26 August 2021 • Minutes of Meeting: 26 August 2021 • Risk Management Strategy 2021/2022 • Principal Risk Document (PRD)	I/09/21	**12.30pm NOTE** **NOTE** **APPROVE** **APPROVE**

OPERATIONAL ISSUES

10	Five Year Equality Review Report **Communications Manager**	J/09/21	**12.45pm** **NOTE**
11	Chief Executive's Update • Mental Capacity Act: Update **Chief Executive**	K/09/21	**1.00pm** **NOTE**
12	Any Other Business		**1.15pm**

Date of Next Meeting: Board Workshop: 14 October 2021, 9.30am

The Regulation and Quality Improvement Authority

Minutes of Authority Meeting

Date of Meeting	9 September 2021
Title of Paper	Public Session Minutes
Agenda Item	2
Reference	Min / Aug21 / public
Author	Hayley Barrett, Business Manager
Presented by	Christine Collins MBE, Interim Chair
Purpose	To provide a record of the meeting of the Authority held on 12 August 2021.
Executive Summary	The minutes contain an overview of the key discussion points and decisions from the Authority meeting on 12 August 2021.
FOI Exemptions Applied	None
Equality Impact Assessment	Not applicable
Recommendation/ Resolution	The Authority is asked to **APPROVE** the minutes of the meeting on 12 August 2021.
Next steps	The minutes will be formally signed off by the Interim Chair.

PUBLIC SESSION MINUTES

RQIA Authority Meeting **Via Zoom** **Thursday 12 August 2021, 5.38pm**	
Present Christine Collins MBE (Interim Chair) (**CC)** Neil Bodger (**NB**) Bronagh Scott (**BS**) Jacqui McGarvey (**JMcG**) Suzanne Rice (**SR**) **Apologies:** Alan Hunter (**AH**) Prof. Stuart Elborn (**SE**) Lynn Long (**LL**)	**RQIA Staff in attendance** Briege Donaghy (Chief Executive) **(BD)** Emer Hopkins (Acting Director of Improvement) (**EH**) Karen Harvey (Professional Advisor Social Work / Project Lead for Assurance) (**KH**) Francis Rice (Professional Advisor Nursing) (**FR**) Jacqui Murphy (Acting Head of Business Support Unit) **(JM)** Malachy Finnegan (Communications Manager) (**MF**) Julie-Ann Walkden, Deputy Director of Assurance (**JAW)** Hayley Barrett (Business Manager) **(HB)**

1.0 Agenda Item 1 - Welcome and Apologies

1.1 The meeting commenced at 5.38pm.

1.2 CC welcomed all Authority Members and RQIA staff to this meeting. Apologies were noted from AH, SE and LL.

2.0 Agenda Item 2 – Minutes of the meeting of the Authority held on 8 July 2021 and matters arising

2.1 The Authority Members **APPROVED** the Minutes of the meeting held on 8 July 2021.

2.2 The Authority Members noted that there were no matters arising.

3.0 Agenda Item 3 - Declaration of Interests

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

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

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

3.4 JMcG advised that she is a member of the NI Social Care Council (NISCC) Board and an Associate with the HSC Leadership Centre, currently involved in the Adolescent Forensic Service.

4.0 Agenda Item 4 – Members Activity Report

4.1 Authority Members **NOTED** the Members Activity Report.

5.0 Agenda Item 5 – Performance Activity Report (PAR): Quarter 1, 2021/2022

5.1 JM presented the Performance Activity Report (PAR): Quarter 1, 2021/2022 and advised that the report is continually being improved following feedback from Authority Members. JM noted that progress relating to the Management Plan is included on pages 35-42.

5.2 In relation to Mandatory Training, JM highlighted a number of technical issues with the Mandatory Training system following the fire, and courses becoming available again in June 2021. JM advised that RQIA has discovered a number of anomalies with the data and a data cleansing exercise is ongoing. KPI's in respect of Complaints, Media and Staff Absence have been met.

5.3 JAW provided an update relating to registration activity, advising of the volume of work and types of registration required, which related to manager applications, manager absences and new services. JAW noted that all cases do not have the same complexities. JAW advised that there is a significant delay in a number of registration activities and an improvement project is included within the Management Plan. Commitments through the Winter Pressures Plan will result in additional staff to help address the delays.

5.4 CC noted a concern due to the delays and the volume of work required to be completed. KH added that there is a plan to address the delayed cases, with the allocation of additional non-recurrent funding , policies and procedures being reviewed and updated, and training being provided. KH noted that this is on the RQIA Principal Risk Document.

5.5 CC expressed concern that customers must be demoralised from the service that they are receiving from RQIA; and staff also feel under pressure from not being able to clear the backlog. JAW advised that she understood the concerns relating to this high level data, however provided assurances that this is monitored on a daily basis with key areas of focus to be addressed. A Project Board, chaired by the Chief Executive, will meet regularly to review progress of the actions to reduce the delays.

5.6 Authority Members discussed the fees relating to registered establishments and asked what the basis of the charging regime is; and if RQIA was charging enough to recover costs.. BD said that consideration of this could be taken forward as part of the Project Board and will need engagement with Sponsor Branch. CC asked that a monthly report relating to the delayed cases of registration activity is presented to the Authority Board.

5.7 <u>Resolved Actions (235)</u>
Monthly report on delayed registration activity to be presented to Authority Meetings.

5.8 JMcG commented that if the Authority Board had a better understanding of Registration Activity and Processes they would be able to provide more support. CC asked that a seminar on Registration is arranged for Authority Members.

5.9 **<u>Resolved Action (236)</u>**
Seminar on Registration Activity to be arranged for Authority Members.

5.10 KH highlighted that the KPI relating to Out of Hours Inspections within the Assurance Directorate has been exceeded during Quarter 1. KH noted that there is ongoing engagement with COPNI in relation to an intelligence / risk based approach to inspection.

5.11 EH explained that, within the Improvement Directorate, that a lot of work has been diverted to Kingsbridge Private Hospital, Intensive Care Unit registration. In additional, the CQC have been providing expert assistance. This is costly, CC noted that this raises again the issue of whether fees are currently set at the appropriate level; and asked for this to be considered as an approach to the Department might be required. EH advised that, during Quarter 1 there were no inspections to Independent Hospitals due to sickness within the team, however, a mitigation plan is being developed.

5.12 JMcG queried if there was a plan in place to address the under delivery in inspections against targets. KH advised that a number of the teams are working with a number of vacancies while staff are being taken off waiting lists; and bank staff is depleted. This reflected the overall pressure on staff throughout the system.

5.13 BS noted an increase in Serious Adverse Incidents (SAIs) and queried if this related to good governance or issues within the services. EH advised that these can fluctuate on a monthly basis so it is difficult to comment on the reasons. EH advised that a number of improvements are being taken forward

across the system relating to SAIs by the HSC Board.

5.14 NB queried if there was an overspill from Enforcement Decision Making (EDM) meetings and other enforcement meetings. EH advised that there could be duplicated services. KH added that there have been fewer EDMs due to early intervention with providers.

5.15 BD said that the PAR is beginning to show the value which enables us to reflect on performance and link the issues to risks and investment planning. BD noted a number of challenges for the organisation relating to the Nicholl Report, Governance Arrangements and the Partnership Agreement with DoH. BD expressed concerns in relation to the organisation's capacity to delivery against all our required responsibilities and that part of our winter planning is connected to seeing what we can do to increase capacity, even if some of that may be short term. Connecting PAR and our risk management is also critical.

5.16 CC noted the importance of understanding the pressures affecting the capacity within RQIA. CC thanked all staff involved for the comprehensive report and noted its usefulness for Authority Members.

5.17 Authority members **APPROVED** the Performance Activity Report (PAR): Quarter 1, 2021/202.

6.0 Agenda Item 6 – Finance Performance Report (Month 3)

6.1 Due to timetabling constraints, Agenda Item 6 was discussed at the beginning 2.10 pm) of the Business in Confidence session of the Authority meeting.

6.2 At this point, Lesley Mitchell (LM) joined the meeting (2.10pm).

6.3 LM advised that, at the workshop on 3 June 2021, the 2021/2022 Financial Plan was presented to outline how RQIA planned to breakeven at year end. LM noted a deficit of £4K at year-end within the 2021/2022 Financial Plan.

6.4 LM informed Members that the projected £91K deficit, due to an increase in the Business Services Organisation (BSO) SLA charge, was indeed an error on the BSO's part and has been rectified.

6.5 LM advised that there has been an increase in income to £677K which includes additional RRL of £227K for the Deceased Patients Review, £70K for a new inspector position for the children's team and administrative support, and £154K assumed pay award funding.

6.6 LM noted that the income of annual fees is increased to date by £25K. LM advised that at the end of Month 3 there is a £199K surplus and a year-end breakeven position of £4K.

6.7 JMcG thanked LM for the report advising that it is showing a clear position at Month 3. CC added that there is now the ability to notify trends.

6.8 NB queried if RQIA sets the fees for establishments. JAW advised that the fees are set out in legislation. NB noted an increase in manager fees. JAW advised that manager fee income is one of the largest elements of additional income for RQIA.

6.9 NB asked for a breakdown of all BSO SLA costs by area. JM confirmed that she would send this to all Authority Members.

6.10 **Resolved Action (237)**
JM to forward a breakdown of SLA costs by area to Authority Members.

6.11 BD advised that RQIA has an in-year spending plan and that a process has been introduced to put forward proposals for in-year spending on a non-recurrent basis. BD advised that, to date, there has been an approval of £100K non-recurrent expenditure.

6.12 Authority members **NOTED** the Finance Performance Report (Month 3).

6.13 At this point, LM left the meeting (2.45pm).

7.0 Agenda Item 7 – Audit and Risk Assurance Committee Update

7.1 NB, Chair of the Audit and Risk Assurance Committee, presented the minutes of the Audit and Risk Assurance Committee of 24 June 2021 for information.

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

8.0 Agenda Item 8 - Part II / SOADs Panel Update

8.1 This item was deferred to the next meeting of the Authority on 9 September 2021.

9.0 Agenda Item 9 – Chief Executive's Update

- **Ethical Advisory Group Terms of Reference**

9.1 EH presented the Ethical Advisory Group's Terms of Reference advising that it is an ethical framework outlining the ethical principles underpinning the Deceased patients Review's work.. EH advised that she would like to ensure that the Authority are able to hold the work of the review Team to account against a firm ethical basis..

9.2 CC thanked EH for this information, advising that there has been a lot of thought gone into the production of this framework. CC suggested writing to the Ethical Advisory Group thanking them for their work, and showcasing it through the RQIA website and other meetings.

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

10.0 Agenda Item 10 – Any Other Business

10.1 As there was no other business, the Interim Chair brought the meeting to a close at 6.16pm.

Date of next meeting:
Thursday 9 September 2021

Signed _____

Christine Collins MBE
Interim Chair

Date _____

Authority Action List

Action number	Authority meeting	Agreed action	Responsible Person	Date due for completion	Status
235	12 August 2021	Monthly report on delayed registration activity to be presented to Authority Meetings.	Deputy Director of Assurance	9 September 2021 and ongoing	
236	12 August 2021	Seminar on Registration Activity to be arranged for Authority Members.	Deputy Director of Assurance	7 October 2021	
237	12 August 2021	JM to forward a breakdown of SLA costs by area to Authority Members.	Acting Head of BSU	9 September 2021	

Key

Behind Schedule	
In Progress	
Completed or ahead of Schedule	

The Regulation and Quality Improvement Authority

RQIA Authority Meeting

Date of Meeting	9 September 2021
Title of Paper	Members Activity Report
Agenda Item	5
Reference	B/09/21
Author	Authority Members
Presented by	Christine Collins MBE
Purpose	To inform the Authority of external engagements and key meetings since 12 August 2021
Executive Summary	External engagements and key meetings since 12 August
FOI Exemptions Applied	None.
Equality Impact Assessment	Not applicable.
Recommendation/ Resolution	The Authority is asked to **NOTE** this report.
Next steps	Not applicable.

MEMBERS ACTIVITY REPORT

Meetings attended by Authority Members

Meeting with Chief Executive	Date
Bronagh Scott	16 August 2021

Audit and Risk Assurance Committee	Date
Neil Bodger Bronagh Scott	26 August 2021

Part II / SOADs Panel	Date
Alan Hunter	27 August 2021

Winter and Services Pressures Resilience Plan 2021/22

3 September 2021

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1.0 Introduction

It is well established that the winter period will see an increase in the demand for health and social care services across Northern Ireland. This is most often recognised by an increased attendance at acute hospital Emergency Departments (ED), with a resultant rise in demand for hospital admissions. The consequences of increased bed occupancy are that there is a resulting need to progress safe and effective discharge from hospital, so that hospital beds are available for new acute admissions. This predictable pressure in the acute setting is mirrored across the wider health and social care system in the increased requirement for domiciliary care services, community and primary care, as well as nursing and residential care homes and other services in social care and mental health settings.

This year the ongoing impact of the COVID-19 pandemic is seeing an increase in ED attendance, normally seen in winter months, experienced during summer. It is likely that as we live with the ongoing impact of the pandemic and the changes it has created and demanded in the provision and delivery of services, that these service pressures will continue and will no doubt rise at times of surges in demand, putting severe pressure across the whole system.

It is in this context that RQIA set out our Winter and Service Pressures Resilience Plan. It is vital that the work of the regulator, in the inspection, review and improvement of services, continues during times of pressures, as the shared endeavour of the whole system is to ensure patient safety. RQIA has a critical and independent role in supporting providers to maintain safety and improve standards, and to ensure the lived experience of those using the services is heard and acted upon.

We are mindful of course that the whole system has had to adapt to new ways of working in response to the pandemic, including virtual appointments, use of technology, remote and home working. Compliance with the use of appropriate PPE, social distancing and other aspects of COVID pandemic guidance must be embedded across the whole system and in our approach to inspections and reviews.

In order to ensure that regulation, inspection and improvement continues during service pressures and as demand increases, we have identified four keys areas to provide a focus and framework for our resilience plan:

1. **Staff Well Being** – we need to look after our staff so that they can effectively do their work and look after the safety and experience of service users and patients.
2. **Supporting Service Providers** – we will proactively support service providers to have access to appropriate guidance, information and support on an ongoing basis.
3. **Continuing inspections and reviews safely** – we will continue our planned inspections and reviews, adopting safe practices and blended approaches

that include physical visits, remote / virtual links, self-reporting and broaden ways to have contact with service users and families.

4. **Improving Communication and Partnership working** – we will work collaboratively with service users, communities, providers and others so that we collectively work to ensure services are safe, effective and continue to improve.

The actions to be taken are set out on page 4 and summarised in Table 1.

There are some very real challenges in delivering this resilience plan particularly in relation to having access to our skilled workforce, who are subject to the same physical and health challenges as is our whole population, and the need to adhere to pandemic restrictions whist continuing with our inspection and review programme. In addition there may be associated costs for mitigating these challenges. We have, as far as possible, included preparations and mitigations for these known challenges as part of our Resilience Plan.

2.0 Underpinning Principles

RQIA has adopted the following principles which underpin the resilience plan:

- Service user / patient safety remains an overriding priority in undertaking our regulation and improvement work throughout the winter and pandemic service pressures;
- We will take all reasonable steps to ensure that we have adequate numbers of skilled staff in order to deliver the work programme, including creating contingency and supplementary staffing to allow flexibility to cope with staff absence and / or increased demand;
- We will work to accommodate the required initiatives or adjustments required to deliver our work programme safely within our own capacity as far as possible, and beyond that seek support from our Sponsor Branch at the Department of Health (DoH);
- We will work as an effective partner with the wider HSC system and independent providers and service users and others, to ensure safety; and
- RQIA remains committed to its legal duties under the HPSS (Quality, Improvement and Regulation) (NI) Order 2003.

3.0 Action Plan

Theme 1: Staff Well Being

Objective : to look after our staff so that they can effectively do their work and look after the safety and experience of service users and patients.

ACTIONS

- We will continue to promote the uptake of the COVID and flu vaccines across our workforce including facilitating access to the vaccine in work premises or providing time to attend for vaccination.
- We will continue to support and encourage our inspector staff to participate in the Trust based regular testing programme for Covid-19.
- Develop events, tools and resources and encourage staff to take part in wellness activities and services. Events are likely to include individual or group zoom. events focussed around personal well being including techniques in mindfulness, physical health, nutrition and hydration, relationships, managing stress and other areas that staff identify as being helpful. We will ask staff views in shaping this programme through a short survey.
- Ensure annual leave is planned and supported.
- Adopt robust use of PPE and COVID compliance on visits, and in the workplace, including limiting time spent with individual staff and service users, where practical.
- Develop and expand our Bank Programme and develop a Peripatetic Inspection and Review Staff Pool. We would plan to: go out to recruit additional staff into these work banks / pools over September 2021; provide induction and orientation to the regulation and inspections legislation and processes over October and November 2021, along with on-the-ground shadowing and preparation; and operationalise staff from December 2021 onwards, where practical and possible. This will assist us to prepare existing and new Inspectors and Reviewers from a wide range of backgrounds, to participate in inspections and reviews across health and social care facilities and provide some flexibility in workforce capacity, also utilising non-recurrent revenue to increase capacity, where available and necessary.
- Show appreciation and recognition for our staff in small gestures and in programmes or events that enable staff to showcase their work, challenges, achievements and learning, with colleagues across the organisation and with our Authority Board.
- Continue to find ways to support staff both individually and as Teams who are working from home.

Theme 2: Support Service Providers

Objective: to provide accessible guidance and support to service providers to help them maintain quality and safety for everyone.

ACTIONS

- Refresh our skill mix in our weekday Guidance Team and improve contact to the Team, so that Providers can get ready access to the appropriate skilled staff.
- Host zoom events for Providers to give opportunity to drill into particular issues and questions.
- Depending on demand / needs, provide the Guidance Team service at weekends / bank holidays.
- Improve our Registration process to address delays for Providers and create a new direct line contact number for queries.
- Update guidance materials on our website.
- Provide self-assessment tools to assist Providers maintain quality standards and improvement beyond formal inspections and reviews.
- Encourage the sharing of best practice and enable benchmarking activities for providers in line with developments within the new RQIA Assurance Framework.
- Encourage staff across services, in both statutory and independent sectors, to take up COVID and flu vaccines.

Theme 3: Deliver a planned programme of Inspections and Reviews

Objective: deliver a planned programme of inspections and reviews adopting approaches that are safe, robust and mindful to the impact of the pandemic.

ACTIONS

- Maintain our scheduled programme of inspections and reviews, while providing practical advice and support to staff, effective feedback and supportive plans for service improvement.
- Develop ways to encourage and listen to the lived experience of service users and families as a critical part of improvement, making available virtual links and use of telephone calls as well as written or verbal submissions.
- Use blended approaches to inspections – including virtual links, self-assessment reports coupled with physical visits, where there is outbreak and need for extra caution in terms of footfall.
- Refresh our Business Continuity plans to ensure we can cope should there be RQIA staff shortage or other resources issues. Also refresh our Emergency Planning arrangements.

Theme 4: Improve Communications and Partnership:

Objective: Improve Communications and Partnership working so that we optimise opportunities for working together to improve services, lived experience and stay safe.

ACTIONS

- Establish a co-produced approach to the development of our Communications and Engagement plans so that service users, communities, providers and others shape how we move forward.
- Update our website so that it is easier to navigate by different users including service users, public and providers, who all have different needs.
- Meet regularly with key Partner organisations including providers, regulators and community and service user representatives and advocates to build relationships and a shared understanding of issues.
- If helpful or required, provide an on-call Senior Officer rota for weekend and bank holidays to participate in partnership working with DoH, Public Health Agency (PHA) and HSC Trusts in responding to significant service issues across sectors.

4.0 Costs and Funding

The delivery of the Resilience plan to address Winter and Service Pressures has some revenue funding consequences. RQIA will aim to accommodate these within existing resources.

RQIA: WINTER & SERVICE PRESSURES PLAN 2021/2022 (Table1)

Objective:
To prepare to safely deliver the regulation and improvement functions and scheduled programme of inspections and reviews, during a period of predicted increased demand across health and social care services

1

Staff Well Being : to look after our staff so that they can effectively do their work and look after the safety of service users and patients

- Promote the uptake of the COVID and flu vaccines across our staff
- Develop events, tools and resources and encourage staff to take part in wellness activities and services. Ask staff views via s short survey.
- Ensure annual leave is planned and supported
- Adopt robust use of PPE and COVID compliance on visits, and in the workplace, including limiting time spent with individual staff and service users
- Develop and expand our Inspectors Bank and develop a Peripatetic Inspector / Reviewer pool, to prepare existing and new Inspectors to participate in Inspections and Reviews
- Show appreciation and recognition for our staff
- Support staff individually and as Teams who are working from home

2

Support Providers: to provide accessible guidance and support to service providers to help them maintain quality and safety for everyone

- Refresh our skill mix in our weekday Guidance Team and improve contact to the Team, so that Providers can get ready access to the appropriate skilled staff
- Host zoom events for Providers to give opportunity to drill into particular issues and questions
- Depending on demand/ needs, provide the Guidance Team service at weekends/ bank holidays
- Improve our Registration process to address delays for Providers and create a new direct line contact number for queries
- Update guidance materials on our web site
- Provide self -assessment tools to assist Providers maintain quality standards and improvement
- Encourage staff across services to take up COVID and flu vaccines

3

Deliver a planned programme of Inspections and Reviews: adopting approaches that are safe, robust and mindful to the impact of the pandemic

- Maintain our scheduled programme of inspections and reviews, while providing practical advice and support to staff, effective feedback and supportive plans for service improvement
- Develop ways to encourage and listen to the lived experience of service users and families as a critical part of improvement , making available virtual links, use of telephone calls
- Refresh our Business Continuity plans to ensure we can cope should there be RQIA staff shortage or other resources issue
- Use blended approaches to inspections – including virtual links, self -assessment reports coupled with physical visits - where there is outbreak and need for extra caution in terms of footfall

4

Improve Communications and Partnership: so that we optimise opportunities for working together to improve services, lived experience and stay safe

- Establish a co-produced approach to the development of our Communications and Engagement plans so that service users, communities, providers and others shape how we move forward
- Update our web site so that it is easier to navigate by different users including service users, public and providers, who all have different needs
- If helpful / required, provide an on-call Senior Officer rota for week-end and bank holidays to participate in partnership working with DoH, PHA and Trusts in responding to significant service issues across sectors

The Regulation and Quality Improvement Authority

Financial Performance Report

31 July 2021

1. FINANCIAL PLAN 2021/22

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

The financial plan is updated monthly and is as follows:

	Revised Financial Plan as at July 2021 **£000**	**Revised Financial Plan as at August 2021** **£000**	**Variance** **£000**	**Latest Best Estimate (LBE) as at 31 March 2022**
RRL	7,611	7,611	0	7,524
Other Operating Income	1,099	1,099	0	927
Total Expected Income	**8,710**	**8,710**	**0**	**8,451**
Pay	7,319	7,319	0	6,882
Non Pay	1,387	1,387	0	1,288
Total Expected Expenditure	**8,706**	**8,706**	**0**	**8,170**
Year End Forecast Surplus/(Deficit)	**4**	**4**	**0**	**282**

A year-end breakeven position continues to be projected, however, a mid-year review will be carried out on the Month 5 financial position to determine if this assumption remains achievable. The outcome of this review will be reported at the next Board meeting.

The above analysis is based on the following assumptions:

- RQIA will contain all costs relating to the Deceased Patients Review (Phase 2) within the allocation of £227k. This also assumes that there will be no slippage on this budget;
- Spending plans will be developed and implemented in-year to absorb any slippage on income, pay and non pay budgets;
- £154k has been assumed in income and expenditure budgets in respect of the pay award for 2021/22.

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

2. FINANCIAL POSITION AS AT 31 JULY 2021

	Full Year Budget £000	Budget YTD 31 July 2021 £000	Actual YTD 31 July 2021 £000	Variance £000
RRL	7,611	2,537	2,537	-
Other Income:				
- Annual Fee	775	258	249	(9)
- Registration of Est. Fees	75	16	47	31
- Registration of Manager	35	12	16	4
- Variation Fees	15	5	5	-
- Dilapidation Compensation	197	63	63	-
- Other Income	2	-	11	11
Total Expected Income	**8,710**	**2,891**	**2,928**	**37**
Pay Expenditure:				
Senior Executives		91	92	1
Assurance Directorate		981	952	(29)
Improvement Directorate		553	542	(11)
Business Support Unit		496	495	(1)
Mental Health Directorate		8	-	(8)
Bank Staff		20	15	(5)
Staff Substitutions		41	36	(5)
Other Pay Costs		10	50	40
Deceased Patients Review		72	68	(4)
Total Pay Expenditure	**7,319**	**2,272**	**2,250**	**(22)**
Non Pay Expenditure:				
Printing, Stationery & Admin		174	175	1
Postage and Telephones		13	7	(6)
Travel Costs		34	18	(16)
Catering		3	-	(3)
Cleaning		5	3	(2)
Building and Engineering		16	(22)	(38)
Heat, Light and Power		3	-	(3)
Rent, Rates and Insurance		111	126	15
Furniture		1	-	(1)
Computer Hardware & Software		30	29	(1)
Advertising		5	-	(5)
Legal Fees & Litigation		-	-	-
Staff Training		10	9	(1)
General Services		46	43	(3)
Other		-	1	1
Deceased Patients Review		3	3	-
Total Non Pay Expenditure	**1,387**	**454**	**393**	**(61)**
Total Expected Expenditure	**8,706**	**2,726**	**2,643**	**(83)**
Surplus/(Deficit)	**4**	**165**	**285**	**120**

The Month 4 financial position is reporting a surplus of £285k, which is an increase of £120k against the budget for the same period. The following issues are to be noted:

- £63k additional income accrued in respect of the compensation element of the dilapidations settlement;
- £37k increase in other income received during the period;
- Pay Budgets are starting to underspend (Month 4 underspend £22k) due to increasing slippage on recruitment of posts (Month 3 overspend £30k);
- Other Pay Costs are overspent by £40k mainly due to an unexpected financial liability in respect of Temporary Injury Benefit;
- Non Pay Budgets continue to underspend by £61k primarily as a result of the dilapidations bill for Lanyon Place being lower than was provided for in the 2020/21 accounts. (Building and Engineering Budget) and also a growing under-spend in the travel budget.

3. DECEASED PATIENTS REVIEW (PHASE 2)

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

	£000
DOH Allocation	227
Costs accrued to 31 July 2021	71
Funding available	**156**

4. KEY MESSAGES

- RQIA continues to project a year-end breakeven position of a surplus amounting to £4k.
- The financial position at 31 July 2021 is reporting a surplus of £285k, which has arisen as a result of additional income and a reduction in expenditure.
- A mid-year review will be carried out on Month 5 financial position to advise on further action required to achieve breakeven;
- The compensation element of the dilapidations settlement has been factored into the financial analysis.
- Funding of £227k has been received from the DOH in respect of the Deceased Patients Review (Phase 2) and as at 31 July 2021 £71k has been spent.

5. GLOSSARY OF TERMS

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

The Regulation and Quality Improvement Authority

RQIA Authority Meeting

Date of Meeting	9 September 2021
Title of Paper	Part II / SOADs Panel Update
Agenda Item	8
Reference	I/09/21
Author	Business Manager
Presented by	Emer Hopkins, Acting Director of Improvement
Purpose	To inform Authority Members of an overview of the Part II / SOADs Panel activity since April 2021.
Executive Summary	Since April 2021 the appointment panel has appointed a total of 47 medical practitioners (Part II) and one Second Opinion Appointed Doctor. Since April 2021, the appointment panel has removed a total of 11 medical practitioners.
FOI Exemptions Applied	None.
Equality Impact Assessment	Not applicable.
Recommendation/ Resolution	The Authority is asked to **NOTE** this report.
Next steps	Not applicable.

BACKGROUND

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

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

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

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

MEMBERSHIP OF THE PART II PANEL

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

The Panel consists of 2 Authority Members:

- Christine Collins
- Alan Hunter

The appointment panel has in attendance

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

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

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

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

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

MEDICAL PRACITIONERS LEAVERS / RETIRED

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

APPENDIX 1 – APPOINTED MEDICAL PRACITIONERS

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

DATE OF MEETING	MEDICAL PRACTIONER	APPOINTMENT TYPE
27 August 2021	Dr Fiona Martin	1st appointment
27 August 2021	Dr Francess Doherty	Re-appointment
27 August 2021	Dr Melissa Wylie	Re-appointment
27 August 2021	Dr Ronan Kehoe	Re-appointment
27 August 2021	Dr Zoe Moore	1st appointment - Locum

APPENDIX 2 – MEDICAL PRACTITIONERS LEAVER / RETIREE

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

MINUTES

RQIA Audit and Risk Assurance Committee Meeting, 26 August 2021
Virtual Meeting, via Zoom, 10.00am

Present
Neil Bodger (NB) (Chair)
Bronagh Scott (BS), Committee Member

In attendance
Briege Donaghy, (BD), Chief Executive
Jacqui Murphy (JM), Acting Head of Business Support Unit
Hayley Barrett (HB), Business Manager

Apologies
Prof. Stuart Elborn CBE (SE), Committee Member
Catherine McKeown (CMcK), Head of Internal Audit, BSO
Brian Clerkin (BC), ASM
David Charles (DC), Assistant Head of Internal Audit, BSO
Stephen Knox (SK), NIAO
Jason McCallion (JM), ASM

1.0 Agenda Item 1 - Welcome and Apologies

1.1 The meeting commenced at 10.03am

1.2 The Chair welcomed all members and officers to the Audit and Risk Assurance Committee meeting. The Chair welcomed Internal Audit, BSO and External Audit to the meeting. Apologies were noted from Prof. Stuart Elborn, Catherine McKeown, BSO Internal Audit and Brian Clerkin, ASM. The Chair noted that BD would be leaving the meeting at 10.30am.

2.0 Agenda Item 2 - Declaration of Interests

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

3.0 Agenda Item 3 - Chairman's Business

3.1 The Chair requested a breakdown of cost details relating to the Service Level Agreement (SLA) with BSO. JM advised that this was also raised at an Authority Meeting and she would re-send the information.

3.2 **Resolved Action (443)**
JM to share with Committee members a breakdown of cost details relating to the SLA with BSO.

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

4.0 Agenda Item 4 - Minutes of Previous Meeting

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

4.1 Committee members noted that the minutes had been approved via email prior to the meeting.

4.2 Committee members **APPROVED** the minutes of the meeting held on 24 June 2021.

4.3 The Chair noted that action 438 remains ongoing. JM advised that Emer Hopkins, Acting Director of Improvement remains in discussions with BSO Procurement and Logistics Service (PaLS) and an update will be provided at the next meeting. All other actions are completed.

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

5.0 Agenda Item 5 – Risk Management Strategy

5.1 BD presented the Risk Management Strategy to Committee members which has been reviewed and revised to meet the current risk management framework and supporting documentation.

5.2 BD highlighted a number of areas of the Strategy to Committee members recognising the importance of the strategy for governance and it embeds an approach aligned to best practice and principles. BD explained that, as the Performance Activity Report is developed, it will become apparent how to mitigate risks associated to performance.

5.3 JM added that, following the training with Amberwing Ltd, good work has progressed with NB to date refining the processes in place. JM outlined that the review of Standing Orders and Partnership Agreement may enable the risk management strategy to be streamlined and amended.

5.4 BS queried if agreeing the risk management approach was a Board responsibility rather than an Executive Management Team responsibility. JM agreed to amend page 11.

5.5 BS advised that she believed that the Directorate Risk Registers would be reviewed more frequently than bi-annually. JM advised that the Directorate Risk Registers are reviewed monthly at team meetings and at EMT on a quarterly basis. JM advised she would update the document.

5.6 BS asked if a comment should be included to reflect the review of standing orders and that the Strategy would be reviewed following this. JM agreed to include an amendment relating to the review of Standing Orders.

5.7 NB expressed the importance of having a Risk Management Strategy and agreed to update the Strategy following the appointment of the new Directors,

review of the Standing Orders and update of documentation in respect of the risk registers.

5.8 JM advised that on page 11, there is reference to annual horizon scanning. JM advised that this will need to be determined as to how this will be taken forward under NB's chairmanship. NB agreed.

5.9 **Resolved Action (444)**
JM to update the Risk Management Strategy to reflect comments raised by Committee members.

5.10 Committee Members **APPROVED** the Risk Management Strategy, subject to minor amendments.

6.0 Agenda Item 6 – Principal Risk Document

6.1 BD presented the Principal Risk Document (PRD) to Committee members advising a few risk ratings and impacts have been amended and one new risk has been added.

6.2 BD advised that actions are being taken to close the gaps in relation to Business Continuity Planning relating to the Winter / Pressures Plan and the impact of the pandemic focusing on elements of staff well-being. BD advised that the plan will articulate with providers and the public.

6.3 BD advised that in relation to ID8, RQIA may not have sufficient resources at the moment. BD explained that the Executive Management Team are reviewing this risk to outline any new mitigations.

6.4 BD advised of a new risk, ID10, relating to registration. BS advised that registration is the core of RQIA work as all establishments are required to register with RQIA and it generates 10% of the organisation's income. BD noted substantial delays in a number of elements of the registration process which may lead to a reputational risk. BD advised that non-recurrent funding has been provided to the Registration Team in order to progress delayed cases.

6.5 At this point BD left the meeting (10.30am).

6.6 JM added that in relation to ID10, there are plans in place to close these gaps as soon as possible with the establishment of a Project Board, chaired by the Chief Executive, which meets on a regular basis.

6.7 BS congratulated JM for getting the Principal Risk Document to this stage and that it is improving and a work in progress. BS felt that there are a number of actions relating to ID8 that could be updated to reflect the "live" position.

6.8 JM advised that ID8 is currently under review by all Directors and their Assistant Directors to ensure that the actions and timeframes are appropriate.

6.9 NB advised that the new layout is proving to be successful in relation to being

user-friendly and easy to follow. NB asked that consideration is given to ensure that new and existing controls, gaps and actions to be taken are put in rank order, one being maximum effect in mitigating the action. NB worked through examples of this with some of the risks and JM agreed to update. JM advised this could be discussed further at the meeting arranged with NB, BD and JM the following week to examine the current risk registers.

6.10 NB asked if the risk rating could be included at the beginning and at the end of each risk.

6.11 JM thanked NB for his comments and agreed to amend ID8 in advance of the meeting with BD and NB.

6.12 NB generated discussion with JM at length in relation to each risk. He asked that timeframes should be specific, i.e. 29 September 2021, rather than September 2021. JM thanked NB for his further feedback and suggested she would pick this up with NB at the meeting the following week. NB advised that if the Communications and Engagement Plan would not be ready until January 2022, no action has been taken to close the gap; therefore the risk impact should not have been reduced.

6.13 JM thanked NB for his detailed feedback.

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

7.0 Agenda Item 7 – Internal Audit Update

- **Progress Report**

7.1 DC presented the Progress Report to Committee members advising that it provides an update on where BSO Internal Audit are with Key Performance Indicators. DC noted at the end of June, 41% of the audit days are now complete.

7.2 DC informed Committee members that one report has been issued in draft relating to Registration Process of Agencies and a second report is due to be issued relating to follow up of recommendations by thematic and governance reviews.

7.3 DC noted that fieldwork has commenced for the Finance Audit. A further update on the progress would be shared at the October meeting.

7.4 NB queried if an aspect of the registration process should be reviewed again next year, following the improvement project. DC confirmed that Internal Audit would be back to review it.

7.5 Committee members **NOTED** the Internal Audit Update.

8.0 Agenda Item 8 – External Audit Update

- **Report to Those Charged with Governance**

8.1 SK advised that the Accounts have been certified on 6 July 2021. SK expressed his thanks to ASM and RQIA colleagues for facilitating the audit.

8.2 JMcC advised that the Report to Those Charged with Governance had been presented to the Audit and Risk Assurance Committee. JMcC noted the recommendations made and the management responses.

8.3 Committee members **NOTED** the Report to Those Charged Governance.

11.0 Agenda Item 9 - Standing Reports to Audit Committee
To include:

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

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

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

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

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

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

11.6 The Business Manager informed Committee members that since the last meeting there have been three further Direct Award Contacts (DAC's) awarded to Care Quality Commission for £11,000, Kaizen Kata for £3,500 and the Royal College of Physicians to support the Deceased Patients of Dr Watts Review for £111,000.

11.7 BS queried why was this awarded as a Direct Contract award and not via the HSC leadership Centre given they would have a number of associates with expertise in this area. JM advised that the HSC Leadership Centre was consulted, as well as the PaLS supplier's list for quality improvement requirements. NHS Scotland had also been sourced through PaLS. NB queried if a specification had been produced in line with the shortlisting. JM advised that she would check with Emer Hopkins, Acting Director of Improvement.

11.8 NB asked for the breakdown of costs relating to the DAC with the Care Quality Commission (CQC). BS noted the complexities in relation to this registration.

11.9 **Resolved Action (445)**
Breakdown of costs relating to the Direct Award Contract with Care Quality Commission to be provided to Chair.

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

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

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

12.0 Any Other Business

12.1 As there was no further business, the Chair of the Committee brought the Audit and Risk Assurance Committee meeting to a close at 11.18am and thanked all for their participation.

Date of Next Meeting: **Thursday 21 October, 10.00am via Zoom**

The Regulation and Quality Improvement Authority

ACTION LIST

RQIA Audit and Risk Assurance Committee Meeting 26 August 2021

Action	Minutes Ref	Agreed Action	Responsible Person	Due date for completion	Status
438	14.11	EH to discuss the rates for staff substitution with the BSO.	Director of Improvement (Acting)	24 June 2021	
443	3.2	JM to share with Committee members a breakdown of cost details relating to the SLA with BSO.	Acting Head of Business Support Unit	21 October 2021	
444	5.9	JM to update the Risk Management Strategy to reflect comments raised by Committee members.	Acting Head of Business Support Unit	21 October 2021	
445	11.9	Breakdown of costs relating to the Direct Award Contract with Care Quality Commission to be provided to Chair.	Business Manager	21 October 2021	

Key

Behind Schedule	
In Progress	
Completed or ahead of Schedule	

~?

The Regulation and Quality Improvement Authority

RQIA ASSURANCE FRAMEWORK: Principal Risks and Controls Document 2021/2022

PRINCIPAL OBJECTIVES: The RQIA Management Plan 2021/2022 is based on 3 Key Strategic Themes as follows:
Theme 1: Safe and Effective Care
Theme 2: People and Communities
Theme 3: Operational Excellence

Item	Principal Risk	Movement since previous PRD	
		Changes to Risk Rating	
		Previous Risk Rating (May 2021)	New Risk Rating (May 2021)
1	Health and Safety	12	8
2	Information Governance	12	No Change
3	Failure to Break Even: RQIA Accounts	6	No Change
4	Disruption to Business Continuity (incl the impact of COVID-19, Accommodation, iConnect)	20	8
5	RQIA Accommodation (Incorporated into ID 4)	12	See ID4
6	Failure to Improve Standards in the Regulated Sector	12	No Change
7	Mental Capacity Act / Mental Health Order	15	No Change
8	Management Arrangements, Resources and Capacity	12	No Change
9	Cyber Security Attack	16	No Change
10	Registration	N/A	20

DOMAIN	IMPACT (CONSEQUENCE) LEVELS [can be used for both actual and potential]				
	INSIGNIFICANT (1)	**MINOR (2)**	**MODERATE (3)**	**MAJOR (4)**	**CATASTROPHIC (5)**
PEOPLE *(Impact on the Health/Safety/Welfare of any person affected: e.g. Patient/Service User, Staff, Visitor, Contractor)*	• Near miss, no injury or harm.	• Short-term injury/minor harm requiring first aid/medical treatment. • Any patient safety incident that required extra observation or minor treatment e.g. first aid • Non-permanent harm lasting less than one month • Admission to hospital for observation or extended stay (1-4 days duration) • Emotional distress (days/weeks).	• Semi-permanent harm/disability (physical/emotional injuries/trauma) (Recovery expected within one year). • Admission/readmission to hospital or extended length of hospital stay/care provision (5-14 days). • Any patient safety incident that resulted in a moderate increase in treatment e.g. surgery required	• Long-term permanent harm/disability (physical/emotional injuries/trauma). • Increase in length of hospital stay/care provision by >14 days.	• Permanent harm/disability (physical/ emotional trauma) to more than one person. • Incident leading to death.
QUALITY & PROFESSIONAL STANDARDS/ GUIDELINES *(Meeting quality/ professional standards/ statutory functions/ responsibilities and Audit Inspections)*	• Minor non-compliance with internal standards, professional standards, policy or protocol. • Audit / Inspection – small number of recommendations which focus on minor quality improvements issues.	• Single failure to meet internal professional standard or follow protocol. • Audit/Inspection – recommendations can be addressed by low level management action.	• Repeated failure to meet internal professional standards or follow protocols. • Audit / Inspection – challenging recommendations that can be addressed by action plan.	• Repeated failure to meet regional/ national standards. • Repeated failure to meet professional standards or failure to meet statutory functions/ responsibilities. • Audit / Inspection – Critical Report.	• Gross failure to meet external/national standards. • Gross failure to meet professional standards or statutory functions/ responsibilities. • Audit / Inspection – Severely Critical Report.
REPUTATION *(Adverse publicity, enquiries from public representatives/media Legal/Statutory Requirements)*	• Local public/political concern. • Local press < 1day coverage. • Informal contact / Potential intervention by Enforcing Authority (e.g. HSENI/NIFRS).	• Local public/political concern. • Extended local press < 7 day coverage with minor effect on public confidence. • Advisory letter from enforcing authority/increased inspection by regulatory authority.	• Regional public/political concern. • Regional/National press < 3 days coverage. Significant effect on public confidence. • Improvement notice/failure to comply notice.	• MLA concern (Questions in Assembly). • Regional / National Media interest >3 days < 7days. Public confidence in the organisation undermined. • Criminal Prosecution. • Prohibition Notice. • Executive Officer dismissed. • External Investigation or Independent Review, Major Public Enquiry.	• Full Public Enquiry/Critical PAC Hearing. • Regional and National adverse media publicity > 7 days. • Criminal prosecution – Corporate Manslaughter Act. • Executive Officer fined or imprisoned. • Judicial Review/Public Enquiry.
FINANCE, INFORMATION & ASSETS *(Protect assets of the organisation and avoid loss)*	• Commissioning costs (£) <1m. • Loss of assets due to damage to premises/property. • Loss – £1K to £10K. • Minor loss of non-personal information.	• Commissioning costs (£) 1m – 2m. • Loss of assets due to minor damage to premises/ property. • Loss – £10K to £100K. • Loss of information. • Impact to service immediately containable, medium financial loss	• Commissioning costs (£) 2m – 5m. • Loss of assets due to moderate damage to premises/ property. • Loss – £100K to £250K. • Loss of or unauthorised access to sensitive / business critical information • Impact on service contained with assistance, high financial loss	• Commissioning costs (£) 5m – 10m. • Loss of assets due to major damage to premises/property. • Loss – £250K to £2m. • Loss of or corruption of sensitive / business critical information. • Loss of ability to provide services, major financial loss	• Commissioning costs (£) > 10m. • Loss of assets due to severe organisation wide damage to property/premises. • Loss – > £2m. • Permanent loss of or corruption of sensitive/business critical information. • Collapse of service, huge financial loss
RESOURCES *(Service and Business interruption, problems with service provision, including staffing (number and competence), premises and equipment)*	• Loss/ interruption < 8 hour resulting in insignificant damage or loss/impact on service. • No impact on public health social care. • Insignificant unmet need. • Minimal disruption to routine activities of staff and organisation.	• Loss/interruption or access to systems denied 8 – 24 hours resulting in minor damage or loss/ impact on service. • Short term impact on public health social care. • Minor unmet need. • Minor impact on staff, service delivery and organisation, rapidly absorbed.	• Loss/ interruption 1-7 days resulting in moderate damage or loss/impact on service. • Moderate impact on public health and social care. • Moderate unmet need. • Moderate impact on staff, service delivery and organisation absorbed with significant level of intervention. • Access to systems denied and incident expected to last more than 1 day.	• Loss/ interruption 8-31 days resulting in major damage or loss/impact on service. • Major impact on public health and social care. • Major unmet need. • Major impact on staff, service delivery and organisation - absorbed with some formal intervention with other organisations.	• Loss/ interruption >31 days resulting in catastrophic damage or loss/impact on service. • Catastrophic impact on public health and social care. • Catastrophic unmet need. • Catastrophic impact on staff, service delivery and organisation - absorbed with significant formal intervention with other organisations.
ENVIRONMENTAL *(Air, Land, Water, Waste management)*	• Nuisance release.	• On site release contained by organisation.	• Moderate on site release contained by organisation. • Moderate off site release contained by organisation.	• Major release affecting minimal off-site area requiring external assistance (fire brigade, radiation, protection service etc).	• Toxic release affecting off-site with detrimental effect requiring outside assistance.

Likelihood Scoring Table			
Likelihood Scoring Descriptors	**Score**	**Frequency** (How often might it/does it happen?)	**Time framed Descriptions of Frequency**
Almost certain	5	Will undoubtedly happen/recur on a frequent basis	Expected to occur at least daily
Likely	4	Will probably happen/recur, but it is not a persisting issue/circumstances	Expected to occur at least weekly
Possible	3	Might happen or recur occasionally	Expected to occur at least monthly
Unlikely	2	Do not expect it to happen/recur but it may do so	Expected to occur at least annually
Rare	1	This will probably never happen/recur	Not expected to occur for years

	Impact (Consequence) Levels				
Likelihood Scoring Descriptors	**Insignificant(1)**	**Minor (2)**	**Moderate (3)**	**Major (4)**	**Catastrophic (5)**
Almost Certain (5)	**Medium**	**Medium**	**High**	**Extreme**	**Extreme**
Likely (4)	**Low**	**Medium**	**Medium**	**High**	**Extreme**
Possible (3)	**Low**	**Low**	**Medium**	**High**	**Extreme**
Unlikely (2)	**Low**	**Low**	**Medium**	**High**	**High**
Rare (1)	**Low**	**Low**	**Medium**	**High**	**High**

RED: Risks added from last Principal Risk Document
BLUE: Risks to be de-escalated/removed from Principal Risk Document

ID	Risk Title	Untreated Risk Rating	Risk Rating (current)	Risk level (current)	Risk Rating (Target)	Risk Level (Target)	Opened	Date of Last Review
1	Health and Safety	20	8	HIGH	6	MEDIUM	October 2020	30 July 2021
2	Information Governance	16	12	HIGH	6	MEDIUM	October 2020	30 July 2021
3	Failure to Breakeven: RQIA Accounts	12	6	MEDIUM	4	LOW	October 2020	30 July 2021
4	Disruption to Business Continuity (including the impact of COVID-19, RQIA Accommodation and iConnect System)	20	8	HIGH	6	MEDIUM	October 2020	30 July 2021
5	RQIA Accommodation (Incorporated into ID 4)	16	12	MEDIUM	9	MEDIUM	October 2020	4 February 2021
6	Failure to Improve Standards in the Regulated Sector	16	12	HIGH	9	MEDIUM	October 2020	30 July 2021
7	Mental Capacity Act / Mental Health Order	25	15	HIGH	9	MEDIUM	February 2021	30 July 2021
8	Management Arrangements, Resources and Capacity	20	12	HIGH	6	MEDIUM	February 2021	30 July 2021
9	Cyber Security Attack	20	16	HIGH	12	HIGH	May 2021	30 July 2021
10	Registration	25	20	EXTREME	16	HIGH	July 2021	30 July 2021

PRINCIPAL RISK REGISTER: ID1

ID 1: Ineffective health and safety management arrangements would increase the risk of harm to our staff and our stakeholders.
Such harm could adversely impact the achievement of our objectives and undermine confidence in RQIA as an employer and a public body.

Consequence (current)	Likelihood (current)	Risk Rating (current)	Risk Level (current)
Major (4)	Unlikely (2)	8	**HIGH**

NEW AND EXISTING CONTROLS	GAPS IN CONTROLS	ACTIONS TO CLOSE GAPS
The following controls are in place: 1. Professional support on Health and Safety is provided by the Health and Safety Manager at Business Services Organisation (BSO) and RQIA's Senior Estates Inspector. 2.Service Level Agreement (SLA) in place with BSO, which includes: • Professional health and safety advice in relation to compliance with statutory Health and Safety requirements; • Advice on the safety of staff; • Provision of Fire Officer Safety Service; • Investigation of Accidents and Incidents, including RIDDOR; • Provision of training on Fire Awareness, Risk Assessment, First Aid at Work, Manual Handling, Evacuation Chair, Defibrillator, Work Station/DSE Assessments; • Development of Health and Safety Policies; • Annual Inspections; • Audits; and • Servicing and Supporting the Health and Safety Committee. SLA is managed and monitored by Business Manager,	1. Fire Safety Mandatory Training: 100% target not met yet.	A meeting with the Health and Safety Manager at BSO took place in October 2020 to discuss how the gaps in assurance would be met: 1. Fire Safety Mandatory Training: Fire Safety Training for staff across HSC organisations has been made available on the eLearning Platform at the end of June 2021. RQIA has identified anomalies in the data and is undertaking a data cleansing exercise. Staff have been reminded to update their Fire Safety Training. Management will also consider alternative sessions provided by BSO, Health and Safety (end of September 2021).

NEW AND EXISTING CONTROLS	GAPS IN CONTROLS	ACTIONS TO CLOSE GAPS
with an annual review of the SLA; Customer feedback meetings; and written assurance updates. 3. Accidents and incidents (including RIDDOR) are managed by RQIA and anything of a serious nature reported to BSO for further review / investigation and possible submission to the Health and Safety Executive (HSE) under RIDDOR. There have been no RIDDOR reportable accidents or incidents over the previous year. 4. COVID-19 (including COSHH) risk assessment completed in October 2020. 5. Fire Inspection undertaken by BSO: BT Tower on 15 December 2020. 6. List of Floor Wardens and Evacuation Chair Operators in place. 7. Display Screen Equipment Assessments are undertaken for staff who require one and adjustments made, as necessary. 8. Revised Policies and Procedures in relation to Health and Safety and Fire Safety Policies and Staff Handbook on Health and Safety available. 9. RQIA Health, Safety and Wellbeing Group established, first meeting took place in April, developing Staff Health and Wellbeing Charter. 10. Fire Risk Assessment carried out for new premises: Victoria House.		
Assurances: Internal (I) and External (E)	1. Regular customer feedback meetings with BSO held (E); 2. Fire Safety inspections by BSO and Action Plans reviewed at EMT (I); 3. COVID-19 Risk Assessments by BSO (E)	

Consequence (target)	Likelihood (target)	Risk Rating (target)	Risk Level (target)
Moderate (3)	Unlikely (2)	6	MEDIUM

Opened	Date of Previous Review	Relates to Strategic Theme(s)	Risk Owner
October 2020	28 May 2021	2. People and Communities 3. Operational Excellence	Interim Chief Executive

PRINCIPAL RISK REGISTER: ID2

ID 2: Ineffective information governance arrangements could contribute to a risk of the safe protection of data and service user information and RQIA's reputation. There is a secondary risk of regulatory action by the Information Commissioner's Office (ICO).

Consequence (current)	Likelihood (current)	Risk Rating (current)	Risk Level (current)
Major (4)	Possible (3)	12	**HIGH**

NEW AND EXISTING CONTROLS	GAPS IN CONTROLS	ACTIONS TO CLOSE GAPS
1. Professional support in relation to Information Governance is provided by the Data Protection Officer (DPO) at Business Services Organisation (BSO) and includes: • Management and handling of information requests under relevant legislation (Freedom of Information Act, Data Protection Act, Environmental Information Regulations); • Provision of advice, expertise and on-site assistance for retrieving and reviewing information for release under DPA, EIR or FOI; • Production of local / monitoring reports in relation to compliance with information requests; • Management and investigation of information security incidents; • Development and delivery of training on a range of information governance issues and advice; • Management and assistance with information governance policies; • Production and management of annual action plan to develop information governance activities; • Audit of Information Governance arrangements; and • Maintenance of Information Asset Registers. SLA is managed and monitored by Business Manager,	1. The Information Governance Suite of Policies provided by BSO is due for review (May 2020). Not reviewed due to COVID-19. 2. Information Management Assurance Checklist (IMAC) return indicates gaps in : • Information Governance Mandatory Training: 95% target not met yet. • An audit of corporate records held by RQIA required to be updated.	1. BSO, as part of SLA agreement, to update relevant policies. Data Protection Officer (DPO) at BSO has advised that Policies have been updated and are awaiting approval by BSO Information Governance Group, whereupon RQIA will review at Policy Sub Group before being adopted across RQIA (end of September 2021). 2. Information Management Assurance Checklist (IMAC) • Information Governance Training for staff across HSC organisations has been made available on the eLearning Platform at the end of June 2021. RQIA has identified anomalies in the data and is undertaking a data cleansing exercise. Staff to complete course in Quarter 2, 2021/2022. • BSO had agreed to undertake an audit of corporate records. DPO at BSO advised that, due to the high volume of FOIs being received at BSO, this has been delayed. Agreed that the audit will be taken forward by new

NEW AND EXISTING CONTROLS	GAPS IN CONTROLS	ACTIONS TO CLOSE GAPS
with an annual review of the SLA; Customer feedback meetings; and written assurance updates. 3. Senior Information Risk Officer (SIRO) and Personal Data Guardian (PDG) in place and trained. 4. Suite of Information Governance Policies provided by BSO. 5. Mandatory Training in Information Governance for all staff available. EMT refresher training took place in June. 6. GDPR: Awareness materials for public on RQIA website. 7. GDPR: Awareness materials for staff disseminated and on RQIA intranet. 8. ICT Asset Register updated and checked on all assets to ensure appropriate tagging by the Web Portal / ICT Administrator. 9. Independent review of Information Governance completed. 10. New Information Governance Group established, with action plan being progressed.	3. Information Governance Review: Recommendations for RQIA.	Information Governance Group, in conjunction with DPO at BSO (end of October 2021). 3. Action Plan developed – being progressed by Information Governance Group under the leadership of Personal Data Guardian (PDG) (end of September 2021).
Assurances: Internal (I) and External (E)	1. Monitoring of Information Governance and ICT security training compliance as part of the Performance Activity Report (PAR) for EMT and RQIA Board (I). 2. Information Incidents and complaints are reviewed when they arise by the Cases and Concerns Committee and EMT (I). 3. The Information Management Assurance Checklist (IMAC) has been completed, with all areas compliant, except for 2 (Training and Records Audit) – addressed in Actions to Close Gaps(E). 4. The Information Governance Group provides assurance to EMT (I) and PDG/SIRO provide assurances to the Audit and Risk Assurance Committee (ARAC).	

Consequence (target)	Likelihood (target)	Risk Rating (target)	Risk Level (target)
Moderate (3)	Unlikely (2)	6	MEDIUM

Opened	Date of Previous Review	Relates to Strategic Theme(s)	Risk Owner
October 2020	28 May 2021	1. Safe and Effective Care 2. People and Communities	Personal Data Guardian Senior Information Risk Owner

PRINCIPAL RISK REGISTER: ID3

ID 3: Failure to achieve a breakeven position as reported in the Annual Accounts (ie a surplus or deficit of less than £20k). This is a Departmental requirement for RQIA and would put at risk the achievement of a key corporate objective.

Consequence (current)	Likelihood (current)	Risk Rating (current)	Risk Level (current)
Moderate (3)	Unlikely (2)	6	**MEDIUM**

NEW AND EXISTING CONTROLS	GAPS IN CONTROLS	ACTIONS TO CLOSE GAPS
1. A full accounting service is provided to RQIA by the BSO Shared Services function and includes: • Reconciliation of Control Accounts • Provision of Monthly Management Accounts • Asset Management • Production of Annual Accounts • Cash Management (including central banking requirements) • Provision of routine financial information • Financial support re fraud awareness, Assembly Questions, Freedom of Information requests, Internal/External audit recommendations. An SLA with BSO is in place, with monitoring arrangements and regular formal meetings. 3. Centralised budget monitored by BSU Business Manager who has been identified as Finance Lead. 4. Financial governance arrangements in respect of the Board are appropriately organised and reflect current DoH guidance. 5. RQIA has the appropriate processes in place to routinely consider and approve the accounts/annual report through its Board Sub-Committee (Audit and Risk Assurance Committee (ARAC) to the Board. 6. ARAC established. Standing reports on Whistleblowing, Fraud and Bribery, Direct Award	1. Gaps in governance processes from recent financial governance review. 2. Inadequate financial management system operating within RQIA, partly due to nature of financial information originating from BSO and a lack of financial expertise housed within RQIA. (Recent Financial Governance Review).	1 and 2 Remaining 4 recommendations from Financial Review to be taken forward when committees meet, to include: 1. SODA being reviewed by Board members - to be presented to future Board meeting. 2. Board self-assessment Governance Tool to be completed by the Chair and Board for Internal Audit (September 2021). 3. Register of Interests and Gifts to be brought to future meetings of ARAC and Board. 4. Hospitality Register to be considered by ARAC and Board. All recommendations to be implemented by October 2021. Currently 82% (18 out of 22) implemented. 2. Financial resource being reviewed as part of the revised examination of the new Corporate Services (end of September 2021).

NEW AND EXISTING CONTROLS	GAPS IN CONTROLS	ACTIONS TO CLOSE GAPS
Contracts & External Consultancy and Update on DoH Circulars presented. 7. Internal Audit arrangements in place and Internal Audit Plan for 2021/2022 includes financial audit. 8. External Audit arrangements are in place and an External Audit Plan to audit the 2020/21 accounts, which is approved by ARAC. 9. Monthly Financial Performance Report is presented to the Board. 10. A financial advisor has been appointed to support financial management during 2020/21 and will be in place for Q1 and Q2 of 2021/22. 11. Costs of COVID-19 response monitored and reported to the DoH, via Monitoring Returns. A Business Case was approved by Department of Health and funding received in 2020/2021. COVID-19 spend continues to be monitored. 12. Zero-based budgets now devolved to AD level, who have received appropriate training. 13. Follow-up Internal Audit provided a Satisfactory status (March 2021). 14. RQIA achieved break-even at year end (31 March 2021).		
Assurances: Internal (I) and External (E)	1. RQIA maintained financial control internally through ongoing budget management processes (I). 2. SLA monitoring of BSO contract which provides accounting services. (I, E) 3. Internal and External audit which covers audit of financial processes and annual accounts. (I, E) 4. Financial reporting at DoH liaison meetings.(E) 5. Appointment of independent financial advisor through HSC Leadership Centre.(I)	

Consequence (target)	Likelihood (target)	Risk Rating (target)	Risk Level (target)
Minor (2)	Unlikely (2)	4	LOW

Opened	Date of Previous Review	Relates to Strategic Theme(s)	Risk Owner
October 2020	28 May 2021	3. Safe and Effective Care 4. People and Communities	Financial Advisor / Associate Acting Head of Business Support Unit

PRINCIPAL RISK REGISTER: ID4

ID 4: Part 1: Pandemic
The Coronavirus Pandemic has had a material impact on the way we conduct our business, on staff working arrangements and on health and safety management. The potential impact of the Pandemic on our objectives has diminished but continuing contingency and health and safety arrangements are required and are largely described in the Management Plan 2021/2022.

ID 4: Part 2: Accommodation: REMOVE
Risk that RQIA will have no headquarters office to operate from after March 2021 following termination of lease by landlord. This has the potential to disrupt business continuity as a consequence of necessary change of headquarters accommodation. –

Consequence (current)	Likelihood (current)	Risk Rating (current)	Risk Level (current)
Major (4)	Unlikely (2)	8	HIGH

NEW AND EXISTING CONTROLS	GAPS IN CONTROLS	ACTIONS TO CLOSE GAPS
Part 1: Pandemic 1. Risk assessment in relation to office space in Riverside Tower, to include COVID-19 aspect, has been undertaken (22 October 2020). 2. PPE in use, both in the office and when undertaking inspections / reviews of healthcare facilities. 3. Flu Vaccine Programme in place for staff. Uptake currently at 52%. Staff currently receiving vaccinations for COVID Vaccine (84% of staff (1st Dose) and 56% (2nd Dose). 4. We have re-orientated our approach from traditional on-site inspections in care homes to virtual, desktop and blended approaches. 5. Where possible, staff are encouraged to work from home. 6. COVID-19 testing programme in place for inspectors. 7. Regular liaison with staff via Zoom meetings, staff weekly updates. Also, liaison with staff side reps via Joint	1. Pandemic / Emergency Response Plan needs revised to reflect current situation and COVID-19 restrictions.	1. Chief Executive to discuss with Chair of Audit and Risk Assurance Committee in the first instance. Then, Response Plan to be updated to ensure comprehensive and reflective of current situation (September 2021). Winter and Service Pressures Delivery Plan to be developed and approved in draft by Authority Board. First version for implementation at Authority Board meeting (September 2021).

NEW AND EXISTING CONTROLS	GAPS IN CONTROLS	ACTIONS TO CLOSE GAPS
Negotiating Forum (JNF). 8. Revised targets (set in April 2021) in relation to achieving statutory functions / minimum requirements for regulated inspection which are reported in PAR, as part of the Performance Framework. 9. Development of inspection schedules and Review Programme taken forward in Management Plan 2021/2022 and as part of the new Assurance Framework. Ongoing dialogue with Sponsor Branch regarding priorities in relation to inspection and review programme. **Part 2: Accommodation: REMOVE** 1. RQIA is part of a wider NICS office estate consolidation project to move identified HSC organisations to James House, Belfast. 2. As part of the James House Project, RQIA is scheduled to move to James House in August 2022. 3. DoF has negotiated an extension of RQIA lease with BT to end of June 2021. 4. BSU Business Manager is part of James House Project Team. 5. Issue escalated to James House Project. RQIA representative on project (BSU Business Manager) to monitor and review, as necessary. 6. BSU Business Manager managing Accommodation Project within RQIA. 7. Business Case to provide temporary office accommodation for RQIA approved by DoH. 8. An Accommodation Sub Group has been established, with regular reporting to the Executive Management Team. 9. Asset (furniture and equipment) write-off approved by ARAC and progressing. 10. Lease terms agreed and lease signed. 11. ICT connectivity to HSC network for new accommodation (Victoria House) in place.		

NEW AND EXISTING CONTROLS	GAPS IN CONTROLS	ACTIONS TO CLOSE GAPS
Assurances: Internal (I) and External (E)	Situation under weekly review via EMT (I) and through liaison with DoH Sponsor Branch and CMO (E)	

Consequence (target)	Likelihood (target)	Risk Rating (target)	Risk Level (target)
Moderate (3)	Unlikely (2)	6	MEDIUM

Opened	Date of Previous Review	Relates to Strategic Theme(s)	Risk Owner
October 2020	28 May 2021	1. Safe and Effective Care 2. People and Communities 3. Operational Excellence	Interim Chief Executive Acting Head of Business Support Unit

PRINCIPAL RISK REGISTER: ID6:

ID6: A failure to improve standards in the regulated sector as a consequence of RQIA not creatively and appropriately responding to external reviews and reports and embedding involvement from service users and stakeholders in our inspection programme in the regulated sector. This has the potential to reduce RQIA's ability to respond to immediate safety and quality concerns in regulated services and thus drive improvement.

Consequence (current)	Likelihood (current)	Risk Rating (current)	Risk Level (current)
Major (4)	Possible (3)	12	**HIGH**

NEW AND EXISTING CONTROLS	GAPS IN CONTROLS	ACTIONS TO CLOSE GAPS
1. Implementation and embedding of three frameworks as part of the Transition Plan 2020/2021: Assurance /Inspection Framework; Performance Framework and Governance Framework, which are flexible, adaptable and responsive to risk and will be used to target our regulatory activity to areas of greatest areas of risk. 2. Intelligence from a wide range of sources is analysed such as: early alerts, whistleblowing, regulatory history, patterns across provider groups, PHA outbreak data, complaints, RADaR, Performance Management at Trust level. 3. Liaison with partner organisations to share and receive information and intelligence. 4. Internal quality assurance mechanisms to support decision-making which include Enforcement Procedures, Inspection Decision-Making Meetings, use of risk analysis, peer reviews, weekly team and directorate safety briefs. 5. A range of assurance methods which include remote, blended and onsite inspections and other means of obtaining evidence from service providers. 6. A range of inspection tools which are continually reviewed and adapted to support our approach to	1. Gaps in involvement and participation of service users and carers in design and ongoing improvement in our inspection approach and reporting templates. 2. Engagement and Involvement Manager not in place. 3. Need to enhance communications and engagement with key stakeholders, using a co-production approach. 4. Staff require refreshed training in Human Rights.	1. Develop, test and evaluate new models to support the integration of lay assessors within assurance / inspection activities. (September 2021) 2. While there was an intention to recruit a senior manager to take forward Engagement, Involvement and PPI, as part of new structure, this has been paused, to address any identified requirements outlined in the Nicholls Review. (October 2021) 3. Authority Board now considering development of a Communications and Engagement Collaborative, to be established for September 2021. 4. Trainer identified to provide Human Rights Training. Service Improvement Officer in Assurance taking forward (September 2021).

NEW AND EXISTING CONTROLS	GAPS IN CONTROLS	ACTIONS TO CLOSE GAPS
inspection and identification of risk in services to improve quality. 7. A review of external reports and recommendations for RQIA was commissioned, delivered and presented to RQIA Board in February 2021 and informed the development of the 2021/2022 Management Plan. 8. Engagement work progressed with Care Opinion, VOYPIC, ARC, AGENI and Alzheimer's society, to focus on user friendly questionnaires. RQIA has embedded a range of regular liaison mechanisms with other agencies, professional regulators, NIMDTA, COPNI, CHASNI, interface meetings with HSC Trusts, CJNI, Police Ombudsman and the Mental Health Champion. 9. New reporting formats have been updated and piloted. 10. A benchmarking exercise was undertaken by Queen's University, Belfast. This evaluated the new assurance framework against best practice in other UK jurisdictions and internationally. This reported in March 2021 and recommendations now built into the Draft Policy Assurance Framework. 11. A new service desk model to deal with concerns, from the public and providers has been piloted and will be subject to evaluation. 12. Funding has been ring-fenced for a new Engagement and Involvement Manager post, recruitment pending. 13. Human Rights-based training delivered to staff.		
Assurances: Internal (I) and External (E)	1. EMT and RQIA Board advised (I). 2. DoH (Sponsor Branch) advised (E).	

Consequence (target)	Likelihood (target)	Risk Rating (target)	Risk Level (target)
Moderate (3)	Possible (3)	9	MEDIUM

Opened	Date of Previous Review	Relates to Strategic Theme(s)	Risk Owner
October 2020	28 May 2021	1. Safe and Effective Care 2. People and Communities	Director of Assurance Acting Director of Improvement

PRINCIPAL RISK REGISTER: ID7

ID7: A failure by RQIA to adequately execute its oversight responsibilities for individuals deprived of their liberty and a breach of its' statutory duties. There is also a risk of failure of RQIA to execute its responsibilities for oversight and its statutory duties for individuals / detained in hospital or detained under guardianship orders in the community, which may result in deficiencies in care or improper detention. In the absence of a clear derogation of the new regulations (Article 276 Mental Capacity Act (MCA) 2016), there is an associated risk of failure by RQIA to provide oversight of authorities holding monies and valuables worth more than £20k without consent will lead a breach of statutory duty and may result in improper use of such funds. These are Statutory Functions of the Authority under either the Mental Capacity Act (2016) and/or Mental Health Order (1986).

Consequence (current)	Likelihood (current)	Risk Rating (current)	Risk Level (current)
Moderate (3)	Almost Certain (5)	15	**HIGH**

NEW AND EXISTING CONTROLS	GAPS IN CONTROLS	ACTIONS TO CLOSE GAPS
1. Inspections to Mental Health wards and other registered establishments in place, which will include reviewing systems for Deprivation of Liberty and Detention under the Mental Health Order. 2. RQIA is collating information relating to requests for consent to hold monies and valuables above £20K without consent under the MCA 2016. 3. A process exists for Mental Health Order detention Form 10's to be scrutinised by healthcare professionals and outcomes shared with each Trust, with administrative checks on remaining mental health detention forms in place. 4. Deprivations of Liberty processes and systems are reviewed as part of current inspection process in Care Homes. Where other intelligence relating to Deprivations of Liberties comes to our attention, it is responded to.	1. A reliable system is not currently in place to receive, consider and provide consent for the holding of funds by HSC Trusts and providers over £20k. 2. A reliable system is not in place to receive, assure and report on forms received for Deprivation of Liberty or notifications for Nominated Persons under the Mental Capacity	RQIA will allocate leadership and administrative resource to support its mental health and learning disability functions. (Sept 2021) 1. Re-submit business case to Department of Health for implementation function, which addresses previous queries. This will enable RQIA to define a new system that would help to provide consent to relevant authorities to hold over £20k in monies and valuables for individuals who lack capacity. This will require developing new operating procedures, identifying resources required and submitting a business case to the Department of Health. 2. It will also enable RQIA to develop options for a system of quality assurance and quantitative reporting of activity related to Deprivation of Liberty or Nominated Person

NEW AND EXISTING CONTROLS	GAPS IN CONTROLS	ACTIONS TO CLOSE GAPS
	Act.	Notifications to RQIA. Prepare an options paper for the Department of Health. (June 2021)
	3. Current administrative arrangements do not provide professional scrutiny of all prescribed forms under the Mental Health Order.	3. Improve the level of professional oversight and scrutiny of mental health detention forms. Identify resources required and submit a business case to the Department of Health, if required. (October 2021)
	4. RQIA is not currently in a position to meet the statutory target of visiting every mental health ward annually and visiting those under guardianship orders in the community.	4. Define resources required to consistently achieve statutory number of inspections to mental health wards and visits to those living in the community under guardianship. Identify additional resources if required and submit a business case to the Department of Health. (September 2021)
Assurances: Internal (I) and External (E)	Gaps in control have been notified to DoH (E)	

Consequence (target)	Likelihood (target)	Risk Rating (target)	Risk Level (target)
Moderate (3)	Possible (3)	9	MEDIUM

Opened	Date of Previous Review	Relates to Strategic Theme(s)	Risk Owner
February 2021	28 May 2021	1. Safe and Effective Care 2. People and Communities 3. Operational Excellence	Deputy Director of Improvement

PRINCIPAL RISK REGISTER: ID8

ID8: RQIA's management arrangements, resources and capacity may limit the organisation's ability to modernise its services and deliver on its corporate objectives.

Consequence (current)	Likelihood (current)	Risk Rating (current)	Risk Level (current)
Moderate (3)	Likely (4)	12	**HIGH**

NEW AND EXISTING CONTROLS	GAPS IN CONTROLS	ACTIONS TO CLOSE GAPS
1. Interim Board with 7 members established in November 2020. Board Committees in place and functioning. 2. Interim Chief Executive appointed from September 2020 and extended to end of June 2021. 3. New Chief Executive recruited on a secondment basis - commencing July 2021. 4 Transition Team in place since October 2020. Arrangements to retain until March 2022 (Director of Assurance) and September 2021 (Professional Nursing Advisor and Financial Advisor). 5. Process completed to review Executive Management Team and directorate structures. 6. Management Plan 2021/2022 agreed and in place. 7. Statement of Strategic Intent developed and agreed by Board - replaces Corporate Strategy 2017-2021. 8. Financial management plan in place and financial advice supplemented by Financial Advisor, Associate from HSC Leadership Centre. 9. Performance management framework in place. 10. Organisational Development Action Plan in place. 11. Communications and Engagement Workshops for Executive Management Team and Chair. Stakeholder analysis undertaken and stakeholder map developed. 12. Increased liaison with other regulators progressing.	1. Over reliance on interim and temporary appointments. 2. Short-term extension of IiP Accreditation in place until November 2021. 3. Limited defined Digital and Intelligence Strategy for the future.	1. Agreed actions required to make shift from Transition Team to established Executive Management Team, with recruitment of 3 x Directors. (September 2021). AND Completion of Restructuring following management of change process: Stage I. (September 2021) and Stage II (December 2021). 2. Decision to undertake IiP in October / November 2021, using INSIGHTS Assessment or STANDARD Assessment, informed by OD Action Plan, with focus on Staff Wellbeing, Staff Recognition and Staff Appreciation (September 2021). Complete the review of skill mix within the organisation and develop staffs' skills and competence through appropriate training. (July 2021) 3. There is a need to set out the drivers and associated business requirement for modernising regulation through a Digital and

NEW AND EXISTING CONTROLS	GAPS IN CONTROLS	ACTIONS TO CLOSE GAPS
13. Critical review of organisation risk ongoing. 14. Active management to reduce number of vacancies and secondments. 15. Appointment of Chief Executive, commenced post 1 July 2021 16. Appointment of Head of Business Support Unit successful in July 2021.		Intelligence Strategy. Strategy Group to be established to support an Intelligence Collaborative (November 2021).
	4. Limitations of information technology system, iConnect.	4. Proposal for funding being submitted to Digital Health and Care NI (DHCNI) and Following discussion with DHSCNI, a Business Case being developed for upgrade of CRM 2011 software on iConnect (October 2021). AND Proposal for capital and revenue funding for full upgrade or replacement for our electronic inspection system, iConnect submitted to DoH. Requires to be submitted to DHCNI by September 2021. If the proposal is accepted, a Business Case will be required.
	5. Under-developed engagement and communication strategy.	5. Review and refresh RQIA's Engagement and Communication Strategy and Plans, as part of the Management Plan 2021/2022 and as part of the Communications and Engagement Collaborative. Project Initiation Document (PID) to be launched and approved at RQIA Board. (January 2022) While there was an intention to recruit a Complaints and Communications Manager to assist in taking forward the Communications and Engagement Strategy, as part of the new structure, this has been paused, to address any identified requirements outlined in the Nicholls Review. (December 2021)
	5. Resource issue: under-funded workstreams, such as work associated with Mental Capacity Act	5.Business cases in progress (October 2021)

NEW AND EXISTING CONTROLS	GAPS IN CONTROLS	ACTIONS TO CLOSE GAPS
	and Deceased Patients Review.	Business case for creation of a Learning Disability Improvement Team and submit to the Department of Health.
Assurances: Internal (I) and External (E)	1. EMT and RQIA Board advised (I). 2. DoH (Sponsor Branch) advised (E).	

Consequence (target)	Likelihood (target)	Risk Rating (target)	Risk Level (target)
Moderate (3)	Unlikely (2)	6	MEDIUM

Opened	Date of Previous Review	Relates to Strategic Theme(s)	Risk Owner
February 2021	28 May 2021	2. People and Communities 3. Operational Excellence	Interim Chief Executive

PRINCIPAL RISK REGISTER: ID9

ID9: There is a risk to the HSC network and organisations in the event of a cyber attack on a supplier or partner organisation, resulting in the compromise of the HSC network and systems, or the disablement of ICT connections and services to protect the HSC and its data. The impact and residual risk on the ability of the HSC to continue to deliver services to patients / service users / customers, compromise or loss of personal and organisational information and loss of public confidence.

Consequence (current)	Likelihood (current)	Risk Rating (current)	Risk Level (current)
Major (4)	Likely (4)	16	**HIGH**

NEW AND EXISTING CONTROLS	GAPS IN CONTROLS	ACTIONS TO CLOSE GAPS
• Regional Information Governance and Advisory Group (IGAG) in place, with RQIA representation. • Risk Management framework in place. • Information Governance processes and monitoring of same. • Emergency planning and business continuity plans. • Disaster recovery plan. • Change control processes. • Data protection legislation. • Trust and Regional Cyber Project Boards. **Technical Infrastructure** - HSC security hardware (e.g. firewalls) / HSC security software (threat detection, antivirus, email & web filtering) / Server / Client Patching / 3rd party Secure Remote Access / Data & System Backups. **Policy / Processes** - Regional and Local ICT/Information Security Policies / Data Protection Policy / Change Control Processes / User Account Management processes / Disaster Recovery Plans / Emergency Planning &	1. Business continuity plans need to be up to date, implemented and regularly tested. 2. Develop and test an Information Governance Emergency Plan in response to a Cyber Attack. 3. ICT security and data protection clauses require to be in all contracts. Partner organisations to meet security and IG standards of the HSC. 4. Legal binding agreements are in place where contracts not required. 5. Review of existing contracts for Security and	1. Business Continuity Plans to be reviewed, updated and testing against the impact of a cyber incident. This will be taken forward in discussion with the Chair of the Audit and Risk Assurance Committee (ARAC) and Chief Executive (September 2021). 2. IGAG to develop an IG management plan in the event of a Cyber incident. 3. Regional IG working group to be established to take forward the review of data flows from HSC/Partner organisations. 4. Supplier framework – to include Security and IG clauses, risk assessment and security management plans. 5. Consider development and use of legally

NEW AND EXISTING CONTROLS	GAPS IN CONTROLS	ACTIONS TO CLOSE GAPS
Service/Business Continuity Plans / Corporate Risk Management Framework, Processes & Monitoring / Regional & Local Incident Management & Reporting Policies & Procedures. **User Behaviours** - influenced through Induction Policy / Mandatory Training Policies / HR Disciplinary Policy / Contract of Employment / 3rd party Contracts / Data Access Agreements.	Data Protection clauses. 6. Residual risk of non-compliance of HSC standards by supplier/partner organisation. 7. Working effectively with partner or supplier organisation during recovery from a cyber attack/ incident (on that partner/ supplier organisation) to seek assurance of Cyber posture before re-engagement of data flows and/or services	binding arrangements to secure best practice. 6. Actions to support Partner/ Supplier Cyber Incident Recovery Planning. 7. Seek a technical report on recovery actions undertaken by the partner/ supplier and consider against known best practice Seek written, evidenced assurances from supplier/partner organisation on the secure transfer and storage of HSC data
Assurances: Internal (I) and External (E)	1. Contract Management and Reviews (I) 2. DAA/MOU (I, E) 3. Supplier/Partner Framework (E) 4. Information Governance Advisory Group (IGAG) (E) 5. Cyber Programme Board (E)	

Consequence (target)	Likelihood (target)	Risk Rating (target)	Risk Level (target)
Major (4)	Possible (3)	12	HIGH

Opened	Date of Previous Review	Relates to Strategic Theme(s)	Risk Owner
Updated from Regional Approach: May 2021	N/A	1. Safe and Effective Care 2. People and Communities 3. Operational Excellence	Interim Chief Executive

PRINCIPAL RISK REGISTER: ID10

ID10: RQIA's management arrangements, resources and capacity in relation to its functions of registration may limit the organisation's ability to deliver on this vital function and subsequently, RQIA's corporate objectives. This could contribute to a risk to the safety and protection, as well of quality of care received by service users If providers operate while not appropriately registered and would have a subsequent negative impact upon RQIA's reputation.

Consequence (current)	Likelihood (current)	Risk Rating (current)	Risk Level (current)
Major (4)	Almost Certain (5)	20	EXTREME

NEW AND EXISTING CONTROLS	GAPS IN CONTROLS	ACTIONS TO CLOSE GAPS
1. Project initiated, with Project Board, chaired by Chief Executive. 2. Weekly update meetings with Project Board 3. Senior Manager (Deputy Director, Assurance) has oversight of this function. 4. Plan in place to address Outstanding Applications. 5. Weekly Monitoring Report for Project Board (detailing outstanding applications). 6. New KPIs being reported to Executive Management Team and RQIA Board via Performance Activity Report (PAR). 7. Triage activated for RQIA Telephone System, with dedicated option for Registration Team.	1. Limited staff resource. 2. Skills, knowledge and experience limited in Registration Team and need identified in relation to comprehensive understanding of customer relationships. 3. Registration Procedures and Processes out of date. 4. Provider Guidance out of date. 5. Recent Internal Audit completed with resulting recommendations in:	1. Agency staff to be recruited (x 4 until end of November 2021 in the first instance and then x2 until end of January 2022) AND recruitment/acquisition of 0.5 WTE Band 7 Inspector (using 2 x Bank Staff to cover). (September 2021) 2. Update Induction and Training (to include Customer Service Training) materials for all staff with registration responsibilities. (November 2021) 3. Review / revise all Procedures and Processes for RQIA staff. (November 2021) 4. Review / revise guidance for Providers and update Website. (October 2021) 5. Address Recommendations from recent Internal Audit on Registration, with a focus

NEW AND EXISTING CONTROLS	GAPS IN CONTROLS	ACTIONS TO CLOSE GAPS
	• KPIs and Timeliness of Registration Processes • Quality Checks and Learning • Guidance for, and Communication with, Applicants	on the Agencies Team in Assurance Directorate (February 2022)
Assurances: Internal (I) and External (E)	Project Board, EMT and RQIA Board advised (I). Internal Audit (E) DoH (Sponsor Branch) advised (E).	

Consequence (target)	Likelihood (target)	Risk Rating (target)	Risk Level (target)
Major (4)	Likely (4)	16	HIGH

Opened	Date of Previous Review	Relates to Strategic Theme(s)	Risk Owner
July 2021	N/A	1. Safe and Effective Care 2. People and Communities 3. Operational Excellence	Interim Chief Executive

RQIA Board Meeting

Date of Meeting	9 September 2021
Title of Paper	Risk Management Strategy
Agenda Item	9
Reference	J/09/21
Author	Business Manager / Acting Head of Business Support
Presented by	Chair of Audit and Risk Assurance Committee (ARAC)
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 2021/2022 has been approved by the Audit and Risk Assurance Committee (ARAC) at its meeting on 26 August 2021. It has been agreed that a further review of this Risk Management Strategy will be undertaken following completion of the review of Standing Orders by the RQIA Authority Board and the refresh of risk register documentation.
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 2021-2022

Policy Type:	Strategy
Directorate Area:	Business Support Unit
Policy Author / Champion:	Business Manager / Chief Executive
Equality Screened:	N/A
Date Approved by Audit Committee:	N/A
Date Approved by RQIA Board:	26 August 2019
Date of Issue to RQIA Staff:	3 September 2019
Date of Review:	Approved by ARAC: 26 August 2021 To be presented to Authority Board: 9 September 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'[2].

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 objectives; operational risks; and risk associated with the protection of its people, property and reputation.

[1] Managing Public Money Northern Ireland (June 2008), Section 4.3 ' Opportunity and Risk'. Cited: March 2021. Available from: https://www.finance-ni.gov.uk/publications/managing-public-money-ni-final-version

[2] Orange Book: Management of Risk – Principles and Concepts. HM Government. (October 2020): Cited: March 2021. Available from: https://www.gov.uk/government/publications/orange-book

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.

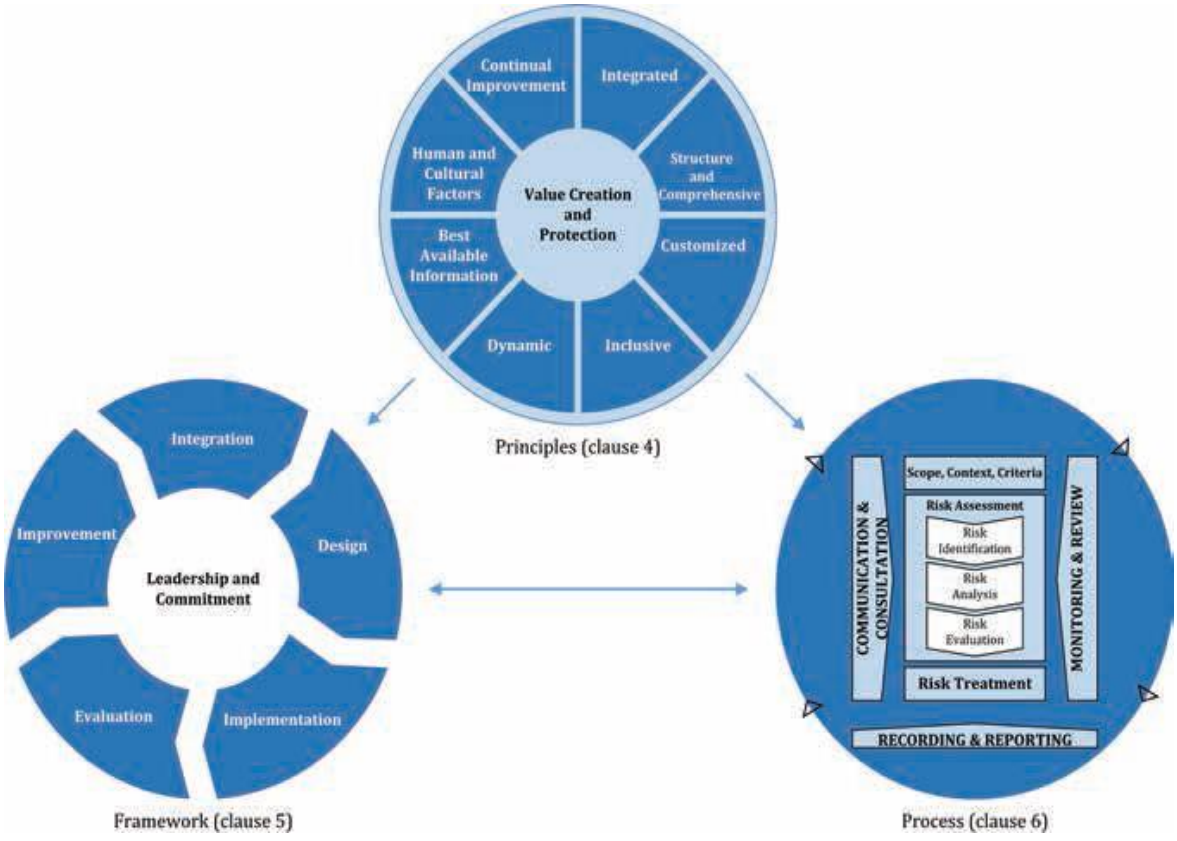
Context

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 is 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[3]



[3] 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 Management 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

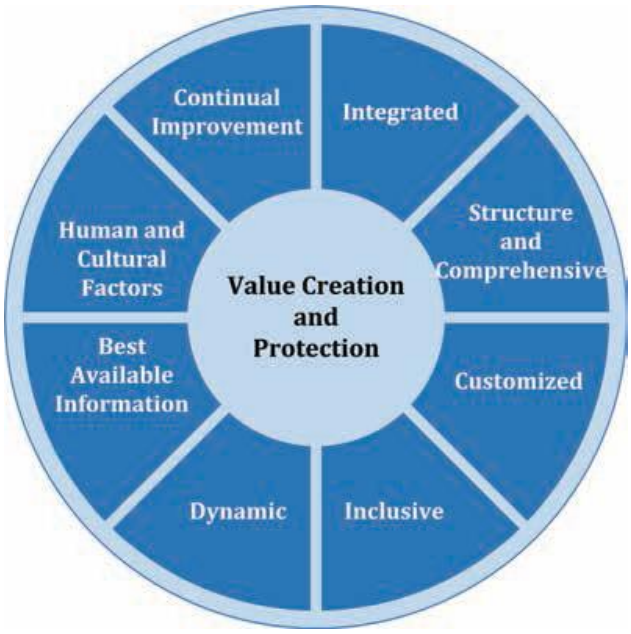
RQIA is committed to implementing the principles of good governance, as the system by which an organisation is directed and controlled, as its most senior levels, in order to achieve its objectives and meet the necessary standards of accountability, probity and openness.

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[4]



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.

[4] 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[5]

[5] 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.

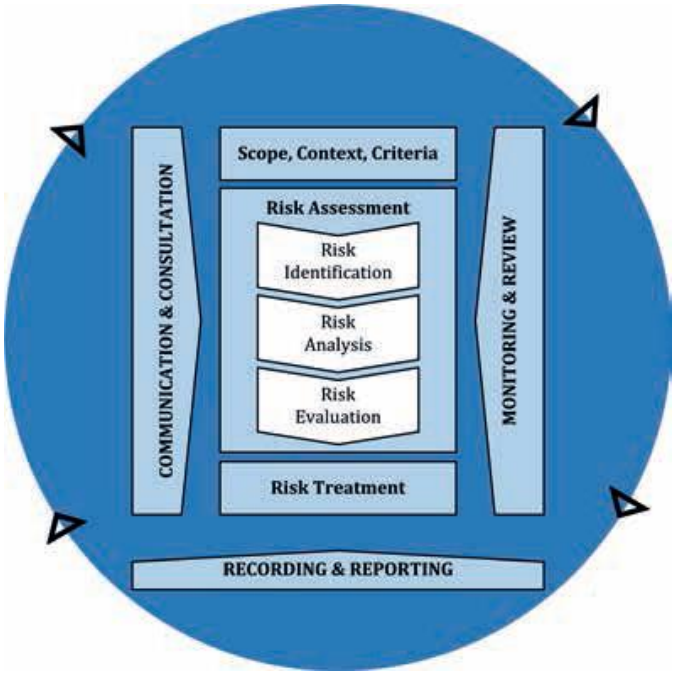
Improvement

- 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[6]



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 A) will provide a guide for analysis.

[6] 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 Authority

The Authority is responsible for ensuring that RQIA has robust and effective arrangements in place for governance and risk management and is responsible for determining RQIA's approach to Risk Management. The Authority is similarly responsible for ensuring that RQIA has effective systems for identifying and managing all risks, financial and organisational. The Authority 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 Assurance Committee on behalf of the Authority.

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 Assurance 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 by:

- Ensuring risk management is embedded into all processes and proactively manage / review the Risk Management Strategy on behalf of the Board and Audit and Risk Assurance 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 and Risk Assurance 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 Principal Risk Document (PRD) (previously the Corporate Risk Assurance Framework Report) and Risk Management Strategy on behalf of the Authority and Audit and Risk Assurance Committee;
- Maintaining the Principal Risk Document (PRD) under the direction of risk owners and updates or amends the PRD 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 has 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, Authority Board and Audit and Risk Assurance Committee.

Audit and Risk Assurance Committee

The Audit and Risk Assurance 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 Assurance Committee.

Audit and Risk Assurance Committee members have responsibility for:

- Reporting to the Authority Board on the effectiveness of the system of internal control and alerting the Authority Board to any emerging issues;
- Recommending the Risk Management Strategy for approval by the Authority Board;
- Overseeing internal audit and external audit findings on risk management processes and risk identification;
- Reviewing and recommending the Principal Risk Document (PRD) for approval by the Authority Board; and
- Engaging with the Executive Management Team 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 Authority 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 informed and proportionate risks, and where relevant in line with the principles of good regulation, 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 six major categories:

- People
- Quality and Professional Standards / Guidelines
- Finance, Information and Assets
- Regulatory and Legal
- Resources
- Environmental

These risks can impact RQIA strategically or operationally and they are not distinct. For example, take informed and proportionate risks, and where relevant in line with the principles of good regulation 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 Authority 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 Registers

The RQIA Principal Risk Document (PRD) is an integral part of the Assurance Process and is used as a mechanism for the Authority Board, Audit and Risk Assurance Committee and Executive Management Team to assess the

effectiveness of controls and assurances which have been identified to manage corporate risks to the achievement of RQIA objectives.

Risk Registers are operationally managed at two levels:

Principal Risk Document (PRD)

The Principal Risk Document will be utilised by the Executive Management Team and Authority Board as a planned and systematic approach for the identification, assessment and mitigation of risks that could compromise achievement of the organisation's Key Strategic / Corporate Objectives. It is a high level assessment of risk to the delivery of key objectives that focuses on adequacy of controls.

The PRD will provide RQIA with a simple, but comprehensive, method for the effective and focused identification and management of the principal risks that arise in meeting its Key Strategic / Corporate Objectives, which focuses on evidence of action or control. It is a comprehensive account of the risks, identified actions required and outstanding gaps in control.

These principal risks are risks which, due to the level of risk involved and/or organisation-wide implications, have been recommended by a Director and accepted by the Chief Executive and Executive Management Team for inclusion in the PRD.

The regional semi-quantitative scoring system is used for assessing risks. Typically principal risks will have higher scores on the rating scale (1 – 25).

The PRD provides an assurance to the Board as to the identification and management of the organisation's Principal risks. The PRD is presented to the Audit and Risk Assurance Committee and to the RQIA Authority Board on a quarterly basis.

Directorate Risk Register quantifies all risks, controls in place and determines the residual risk that remains. It is comprised of all the risks for each function 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 monthly to their Director. Directorate risk registers are reviewed by the Executive Management Team on a regular basis, usually quarterly.

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 Principal Risk Document / Directorate Risk Registers. The Chief Executive, in conjunction with the Chair of the Audit and Risk Assurance Committee and the Head of the Business Support Unit, are undertaking a review of risk documentation and considering replacement of the separate Directorate Risk Registers with a Corporate Risk Register, which will delineate risks by Directorate / Service Area.

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 in the relevant risk register.

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 Authority Board, Audit and Risk Assurance Committee and the Executive Management Team to capture strategic corporate risks. There is an opportunity for new and emerging risks to be discussed through the Executive Management Team meetings, the Audit and Risk Assurance Committee and the Authority 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, a risk likelihood scoring table and impact criteria is outlined in Appendix A. This then feeds into the overall Risk Scoring Matrix for evaluating the risk.

For each risk, a risk score should initially be determined before any controls are applied. This is the untreated risk score/rating.

The current 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 untreated and current risk scores/ratings can be used to prioritise all risks across the organisation.

The risk scoring matrix 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 (Consequence) Levels				
Likelihood Scoring Descriptors	**Insignificant (1)**	**Minor (2)**	**Moderate (3)**	**Major (4)**	**Catastrophic (5)**
Almost Certain (5)	Moderate	Moderate	High	Extreme	Extreme
Likely (4)	Low	Moderate	Moderate	High	Extreme
Possible (3)	Low	Low	Moderate	High	Extreme
Unlikely (2)	Low	Low	Moderate	High	High
Rare (1)	Low	Low	Moderate	High	High

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
Principal Risk Document (Corporate)	Audit and Risk Assurance Committee / Authority Board	Remains on the Principal Risk Document
Directorate	Director / Executive Management Team	Escalate to Principal Risk Document (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
Principal Risk Document (Corporate)	The Risk Owner should engage with the Head of Business Support Unit. The Head of Business Support Unit will include the suggested risk for consideration by the Executive Management Team and Chief Executive then put it forward to the Audit and Risk Assurance Committee / Authority Board for approval.	Audit and Risk Assurance Committee / Authority Board
Directorate	The risk identifier should contact the relevant Director (risk owner), who 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. 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 Principal Risk Document and Directorate Risk Registers are subject to regular monitoring. The Principal Risk Document is reported to the Executive Management Team and to the Audit and Risk Assurance Committee and the Authority Board on a quarterly basis. Directorate Risk Registers should be submitted to the Executive Management Team and to the Audit and Risk Assurance Committee on a quarterly 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 Authority 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; and
- 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 B is presented and available to all staff, particularly new recruits. The Audit and Risk Committee Handbook (NI) 2018 DAO (DOF) 3/18[7] is issued to all Audit and Risk Assurance Committee Members and the Executive Management Team.

[7] The Audit and Risk Committee Handbook (NI) 2018 DAO (DOF) 3/18 (April 2018). Cited: March 2021. Available from: https://www.finance-ni.gov.uk/sites/default/files/publications/dfp/daodof0318att.pdf

Review

The Risk Management Strategy is subject to annual review and Authority Board approval.

The Strategy is currently under review in 2021/2022 and has been approved by the Audit and Risk Assurance Committee on 26 August 2021, prior to being presented to the RQIA Authority Board in September 2021.

It has been agreed that a further review of this Risk Management Strategy will be undertaken following completion of the review of Standing Orders by the RQIA Authority Board and the refresh of risk register documentation.

Appendix A

Risk Likelihood Scoring Table

Risk Likelihood Scoring Table			
Likelihood Scoring Descriptors	**Score**	**Frequency (How often might it/does it happen?)**	**Time framed Descriptions of Frequency**
Almost certain	5	Will undoubtedly happen/recur on a frequent basis	Expected to occur at least daily
Likely	4	Will probably happen/recur, but it is not a persisting issue / circumstances	Expected to occur at least weekly
Possible	3	Might happen or recur occasionally	Expected to occur at least monthly
Unlikely	2	Do not expect it to happen/recur but it may do so	Expected to occur at least annually
Rare	1	This will probably never happen/recur	Not expected to occur for years

HSC Regional Impact Table

DOMAIN	IMPACT (CONSEQUENCE) LEVELS [can be used for both actual and potential]				
	INSIGNIFICANT (1)	**MINOR (2)**	**MODERATE (3)**	**MAJOR (4)**	**CATASTROPHIC (5)**
PEOPLE *(Impact on the Health/Safety/Welfare of any person affected: e.g. Patient/Service User, Staff, Visitor, Contractor)*	• Near miss, no injury or harm.	• Short-term injury/minor harm requiring first aid/medical treatment. • Any patient safety incident that required extra observation or minor treatment e.g. first aid • Non-permanent harm lasting less than one month • Admission to hospital for observation or extended stay (1-4 days duration) • Emotional distress (recovery expected within days or weeks).	• Semi-permanent harm/disability (physical/emotional injuries/trauma) (Recovery expected within one year). • Admission/readmission to hospital or extended length of hospital stay/care provision (5-14 days). • Any patient safety incident that resulted in a moderate increase in treatment e.g. surgery required	• Long-term permanent harm/disability (physical/emotional injuries/trauma). • Increase in length of hospital stay/care provision by >14 days.	• Permanent harm/disability (physical/ emotional trauma) to more than one person. • Incident leading to death.
QUALITY & PROFESSIONAL STANDARDS/ GUIDELINES *(Meeting quality/ professional standards/ statutory functions/ responsibilities and Audit Inspections)*	• Minor non-compliance with internal standards, professional standards, policy or protocol. • Audit / Inspection – small number of recommendations which focus on minor quality improvements issues.	• Single failure to meet internal professional standard or follow protocol. • Audit/Inspection – recommendations can be addressed by low level management action.	• Repeated failure to meet internal professional standards or follow protocols. • Audit / Inspection – challenging recommendations that can be addressed by action plan.	• Repeated failure to meet regional/ national standards. • Repeated failure to meet professional standards or failure to meet statutory functions/ responsibilities. • Audit / Inspection – Critical Report.	• Gross failure to meet external/national standards. • Gross failure to meet professional standards or statutory functions/ responsibilities. • Audit / Inspection – Severely Critical Report.
REPUTATION *(Adverse publicity, enquiries from public representatives/media Legal/Statutory Requirements)*	• Local public/political concern. • Local press < 1day coverage. • Informal contact / Potential intervention by Enforcing Authority (e.g. HSENI/NIFRS).	• Local public/political concern. • Extended local press < 7 day coverage with minor effect on public confidence. • Advisory letter from enforcing authority/increased inspection by regulatory authority.	• Regional public/political concern. • Regional/National press < 3 days coverage. Significant effect on public confidence. • Improvement notice/failure to comply notice.	• MLA concern (Questions in Assembly). • Regional / National Media interest >3 days < 7days. Public confidence in the organisation undermined. • Criminal Prosecution. • Prohibition Notice. • Executive Officer dismissed. • External Investigation or Independent Review (eg, Ombudsman). • Major Public Enquiry.	• Full Public Enquiry/Critical PAC Hearing. • Regional and National adverse media publicity > 7 days. • Criminal prosecution – Corporate Manslaughter Act. • Executive Officer fined or imprisoned. • Judicial Review/Public Enquiry.
FINANCE, INFORMATION & ASSETS *(Protect assets of the organisation and avoid loss)*	• Commissioning costs (£) <1m. • Loss of assets due to damage to premises/property. • Loss – £1K to £10K. • Minor loss of non-personal information.	• Commissioning costs (£) 1m – 2m. • Loss of assets due to minor damage to premises/ property. • Loss – £10K to £100K. • Loss of information. • Impact to service immediately containable, medium financial loss	• Commissioning costs (£) 2m – 5m. • Loss of assets due to moderate damage to premises/ property. • Loss – £100K to £250K. • Loss of or unauthorised access to sensitive / business critical information • Impact on service contained with assistance, high financial loss	• Commissioning costs (£) 5m – 10m. • Loss of assets due to major damage to premises/property. • Loss – £250K to £2m. • Loss of or corruption of sensitive / business critical information. • Loss of ability to provide services, major financial loss	• Commissioning costs (£) > 10m. • Loss of assets due to severe organisation wide damage to property/premises. • Loss – > £2m. • Permanent loss of or corruption of sensitive/business critical information. • Collapse of service, huge financial loss
RESOURCES *(Service and Business interruption, problems with service provision, including staffing (number and competence), premises and equipment)*	• Loss/ interruption < 8 hour resulting in insignificant damage or loss/impact on service. • No impact on public health social care. • Insignificant unmet need. • Minimal disruption to routine activities of staff and organisation.	• Loss/interruption or access to systems denied 8 – 24 hours resulting in minor damage or loss/ impact on service. • Short term impact on public health social care. • Minor unmet need. • Minor impact on staff, service delivery and organisation, rapidly absorbed.	• Loss/ interruption 1-7 days resulting in moderate damage or loss/impact on service. • Moderate impact on public health and social care. • Moderate unmet need. • Moderate impact on staff, service delivery and organisation absorbed with significant level of intervention. • Access to systems denied and incident expected to last more than 1 day.	• Loss/ interruption 8-31 days resulting in major damage or loss/impact on service. • Major impact on public health and social care. • Major unmet need. • Major impact on staff, service delivery and organisation - absorbed with some formal intervention with other organisations.	• Loss/ interruption >31 days resulting in catastrophic damage or loss/impact on service. • Catastrophic impact on public health and social care. • Catastrophic unmet need. • Catastrophic impact on staff, service delivery and organisation - absorbed with significant formal intervention with other organisations.
ENVIRONMENTAL *(Air, Land, Water, Waste management)*	• **Nuisance release.**	• **On site release contained by organisation.**	• Moderate on site release contained by organisation. • Moderate off site release contained by organisation.	• Major release affecting minimal off-site area requiring external assistance (fire brigade, radiation, protection service etc).	• **Toxic release affecting off-site with detrimental effect requiring outside assistance.**

The Regulation and Quality Improvement Authority

RISK-ON-A-PAGE

Appendix B

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, Management 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 (Consequence) Levels				
Likelihood Scoring Descriptors	Insignificant(1)	Minor (2)	Moderate (3)	Major (4)	Catastrophic (5)
Almost Certain (5)	Moderate	Moderate	High	Extreme	Extreme
Likely (4)	Low	Moderate	Moderate	High	Extreme
Possible (3)	Low	Low	Moderate	High	Extreme
Unlikely (2)	Low	Low	Moderate	High	High
Rare (1)	Low	Low	Moderate	High	High

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 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

MONITOR AND REVIEW

- RQIA Risk Management Strategy (update and approve annually)
- Principal Risk Document (PRD) (update quarterly)
- Directorate Risk Registers (update monthly)
- Risk documentation located at: M:\Shared_Area\RQIA Risk Management Folder

The Regulation and Quality Improvement Authority

RQIA Authority Meeting

Date of Meeting	9 September 2021
Title of Paper	RQIA Five Year Review of Equality Scheme
Agenda Item	10
Reference	K/09/21
Author	BSO Equality Unit on behalf of RQIA
Presented by	Acting Head of Business Support Unit
Purpose	To provide Authority Members an opportunity to approve RQIA's Five Year Review of Equality Scheme.
Executive Summary	All public bodies are required to review their Equality Scheme under Section 75 of the Northern Ireland Act (1998) every five years. The purpose of this review is to take learning and set direction for the coming years by critically evaluating the way the organisation has implemented Section 75 over the past five years. This review involved a process of self-assessment, examining what has been achieved, what remains to be done, and lessons learned. This was based on evidence from the organisation from previous Annual Progress Reports on the implementation of Section 75 and the outcomes of a workshop held with RQIA's Executive Management Team, facilitated by BSO's Equality Unit. This report presents background information on the organisation, the methodology, and the key findings from the review.. The concluding section aims to address the Equality Commission's requirements in relation to a summary of the main findings.
FOI Exemptions Applied	None
Equality Impact Assessment	Not applicable
Recommendation/ Resolution	The Authority is asked to **APPROVE** this paper.
Next steps	

RQIA Five Year Review of Equality Scheme

June 2021

[RQIA to insert date of approval by Board]

Contents

Five Year Review of RQIA Equality Scheme

1. Introduction

Like all public bodies, the Regulation and Quality Improvement Authority (RQIA) has committed to reviewing its Equality Scheme under Section 75 of the Northern Ireland Act (1998) every five years. Ultimately, the purpose of the review is to take learning and set direction for the coming years by critically evaluating the way the organisation has implemented Section 75 over the past five years.

The review is a process of self-assessment. As specified by Equality Commission guidance[1] , the review involves looking at what has been achieved, what remains to be done, and lessons learned. It should be based on evidence. The guidance states that the collection and consideration of additional quantitative and qualitative data may be necessary, alongside use of existing information from previous Annual Progress Reports on the implementation of Section 75.

This report presents the key findings from the review. Background information on the organisation and the methodology of the review is included in the opening section. The scope and structure of the concluding section is designed to cover the Equality Commission's requirements in relation to a summary of the main findings.

2. Background

2.1 The organisation

The Regulation and Quality Improvement Authority (RQIA) is the independent body responsible for monitoring and inspecting the availability and quality of health and social care services in Northern Ireland, and encouraging improvements in the quality of those services.

Through our inspections, reviews and audits, RQIA provides assurance about the quality of care, challenges poor practice, promotes improvement and safeguards the rights of service users. We inform the public of our findings through the publication of our reports.

We work with our colleagues across health and social care and service providers so that they can deliver improved care. We also are dedicated to hearing and acting on the experiences of patients, clients, families and carers. It is only by working in partnership with service users and providers of care that we can encourage and influence improvement.

[1] Equality Commission for Northern Ireland (2016): Guidance on conducting a 5 year review of an equality scheme.

RQIA carries out a number of programmes of work including:

- Registration and inspection of independent and statutory health and social care services. Every year we inspect around 1,500 health and social care services. These include almost 500 nursing and residential care homes as well as children's homes; domiciliary care and nursing agencies; adult day care services; private dental clinics; and independent hospitals and hospices and clinics. We also inspect the quality of care in acute hospitals, mental health and learning disability wards and in places of detention including prisons.
- A programme of reviews to assure the quality of services provided by the HSC Board, HSC trusts and agencies.
- Wide ranging responsibilities for people with mental ill health and those with a learning disability.
- An infection prevention and hygiene inspection programme.
- A programme of radiological inspections in relation to Ionising Radiation (Medical Exposure) Regulations.

RQIA currently comprises around 120 members of staff.

2.2 Methodology of the review

This review was undertaken in partnership with the other regional HSC organisations, supported by the Business Services Organisation (BSO) Equality Unit. It involved the collection of both quantitative and qualitative data.

The quantitative data elements informing the review include:

- A desk-top exercise looking at in-house data, including RQIA figures on staff training and equality screenings over the five year review period, as well as Corporate reports and Business Plans.
- RQIA Annual Progress Reports to the Equality Commission (2016-17 to 2019-20) as well as quarterly equality screening reports for 2020-21.
- A questionnaire examining key areas of Section 75 implementation was completed by the RQIA Equality Lead (RQIA Communications Manager).

Qualitative data sources comprised a series of interviews and focus groups with key stakeholders. This included:

- an interview with the Equality Lead in RQIA;
- a focus group organised by the Equality Unit on behalf of RQIA with members of Tapestry, the staff disability network. Tapestry is made up of staff from the 11 regional HSC organisations who have an interest in disability or carer's issues.
- a focus group with members of the regional HSC Equality Forum, which brings together the equality leads in the 11 regional HSC organisations;

- a focus group with RQIA Executive Management Team was also facilitated by the Equality Unit, to explore lessons learned, key priorities and actions for Equality Scheme implementation over the coming years.

3. Key Findings

3.1 Outcomes (Section 75 and Good Relations duties)

3.1.1 Staff

Over the last five years, RQIA has raised awareness of support sources for staff with a range of health issues and disabilities. These include events organised by RQIA at Riverside Tower, in partnership with a range of organisations including: Cancer Focus, Diabetes UK, Royal National Institute for the Blind, Alzheimer's Society, Cruise Bereavement, and eating disorders charities.

RQIA has invested heavily in health and wellbeing work, including the development of a Health and Wellbeing Staff group. Important outcomes have been produced through this work, including raising awareness of how to support staff with mental and emotional wellbeing issues. This work has intensified over the last 12 month period during the COVID pandemic.

RQIA has made progress in identifying and seeking to address the needs of staff who have dependents, by making staff aware of support available, including both HR policies, as well as other practical sources of support, such as respite care and Carers' Assessments. We have also developed Flexible Working policies and procedures. This includes looking at different ways we can support staff with caring responsibilities, e.g. through remote or home working.

Also, regarding staff with disabilities, promotion of disability events such as staff awareness days have proved to be effective in increasing awareness, knowledge and skills of staff and line managers in meeting the needs of colleagues with a particular disability.

We also have a strong partnership with the Equality Unit in BSO in working on equality issues to do with disability, including active participation in the Disability Placement scheme. Since the start of the Disability Scheme, we have offered 5 placements.

One participant on the scheme has been successful in gaining a permanent post within the RQIA, and another took up employment in another HSC organisation. However, as evidenced through self-reporting by participants as well as placement managers and employment support officers as the key stakeholders of the scheme, outcomes extend beyond employment and employability to increased confidence levels, a reduction in social isolation and improved mental health of participants.

In turn, participating teams and line managers have gained invaluable knowledge and skills in identifying and meeting the needs of people with a disability in the workplace.

In addition, our staff Disability Network, Tapestry, has given a platform to staff who have a disability to raise and discuss disability issues in a safe environment.

While the RQIA's Accessible Formats policy has been useful in improving public access to information, Tapestry members found that across the HSC organisations, significant gaps persist in accessibility of information for staff. Accessibility issues were also identified in relation to recruitment and selection processes and training.

Staff with sensory loss and those with a learning disability report significant barriers resulting from a lack of accessibility in policies and procedures, the systems used (such as HRPTS and eProcurement) and general information shared with all staff was not accessible to them. This applies to information relating to the recruitment and selection process (including pre-employment checks) once staff with a disability are in post. Likewise, mainstream training is largely inaccessible for them, both as to training course materials, e-learning, and a lack of trainers' understanding of the specific information and communication needs of staff with a disability.

3.1.2 Service users

During 2018-19 RQIA's inspectors attended a programme of human rights training which reinforced awareness and understanding of key equality issues. This supports RQIA in ensuring providers have a clear focus on equality matters and take account of Section 75 considerations in developing and delivering their services.

Carers: Events organised by the RQIA have focused on family interventions in acute dementia services, with speakers sharing their experiences of their relative's care. Staff from each Trust described the interventions they have used to support, promote and develop patient experience through family involvement in a ward setting.

Disability: Work to date has produced positive outcomes for Elderly and Brain injured people, as well as Supporting Families and Dementia Care in Northern Ireland, with views sought from carers and Trust staff from across Northern Ireland to share examples of best practice, including Dementia Champions Model and the Patient Centred Model.

RQIA's Mental Health and Learning Disability (MHLD) team inspectors developed a direct observation tool for use on wards for patients who have no capacity to allow them to answer or understand a structured questionnaire. The Quality of Interaction Audit was a tool designed to help evaluate the type and quality of communication that takes place on a ward. The tool was designed to help inform evaluations of the

type and quality of interaction that takes place between staff and patients and their visitors in a mental health or learning disability hospital setting.

Marital status: In our work with care homes, we have highlighted that many of the rooms are single occupancy. We have been raising awareness with care homes that double occupancy rooms also need to be made available, in order to accommodate the needs of service users who are married or who are in relationships.

We have also undertaken a number of reviews over the last five years of health and social care in criminal justice services. RQIA's reviews aim to identify best practice, to highlight gaps or shortfalls in services requiring improvement and to protect the public interest. Topics for review are informed by consultation with service users, the public and other key stakeholders, and cover a number of different disciplines.

Review programmes over the last five years relating to key Section 75 groups include:

- Age: for example, reviews into services provided for Children and Young people, such as the Review of General Paediatric Surgery in Northern Ireland (NI) which identified areas of good practice and made recommendations for improvements for the outcomes of children and young people having surgery in NI.
- Gender: for example, the review of Perinatal Mental Health Services in NI, which highlighted a shortfall in the services provided to women who had given birth, and suggested ways of improving their access to services.
- Disability: including a review of Guidelines on Caring for People with a Learning Disability in General Hospital Settings, to enhance safe and effective care for people with a learning disability throughout their hospital journey.

Other examples of work in this field includes

- the Review into Emergency Mental Health Service Provision in NI, which identified issues affecting the delivery of a quality service for mental health service users, their families and carers.

Lessons learned:

- By engaging with patients and service users, we have heard first-hand about their experiences, and can then make recommendations for service improvement.
- We recognise that individuals can fall into more than one equality category. Although we have published a number of reviews over the last five years relating to Section 75 groups, these have not examined diversity within each of these categories. For example, although the Review of Perinatal Mental Health Services in NI aims to improve services for women, it does not consider the diversity within this group. For example, women from different ethnic minority groups or women with disabilities may experience different needs with regard to help-seeking, accessing and utilising services.
- Working in partnership with advocacy organisations has produced positive outcomes for certain Section 75 groups. For example, work with the Voice Of

Young People In Care (VOYPIC) and care experienced young people to allow our inspectors to refine our inspections of children's homes. However, again we recognise that there is no evidence that the diverse needs of young people in care are met through our inspections.

- Also, work with Action on Hearing Loss, RNIB (Royal National Institute for the Blind), Carafriend and other groups supporting people of different sexual orientations has raised awareness of parts of the community that are often invisible, and highlighted to us that we need to be aware of those who have different needs and expectations.
- We have made improvements to our information materials (both in terms of our reports, and corporate information such as how to make a complaint) through the production of easy read formats in order to facilitate the needs of those with learning disabilities.

Looking ahead:

- In relation to our workforce we will devote more attention to the needs of our staff who are carers. We will raise awareness of the HSC Staff Network supporting staff of different sexual orientations and gender identities; and Tapestry, the HSC Staff Disability Network. This will not only raise visibility and awareness of these groups, but will also support staff within these Section 75 categories.
- We will work with the other regional organisations and BSO to ensure that the design specifications for new systems relating to HR, Finance and Procurement as well as any new eLearning programmes meet accessibility standards in order to meet the needs of staff and candidates with different disabilities.
- We will look at gaps in certain work programmes. For example, inspections of Domiciliary Care and Care Homes for Older People will include consideration of the needs of other Section 75 groups. This will initially focus on sexual orientation and gender, in line with DoH Guidance "See Me, Hear Me, Know Me" aiming to support the needs of older lesbian, gay, bisexual and transgender people in nursing, residential, and day care settings, and those who live at home receiving domiciliary care.
- Several of our inspection reports in criminal justice institutions have already highlighted gaps in relation to consideration of the needs service users of different sexual orientations. We will work with voluntary organisations, service providers, and our partners in the PHA and Justice sector to meet the needs of those of different sexual orientations.

3.2 Business Planning, Policy and Decision Making, and Governance

3.2.1 Planning

While our Corporate Strategy 2017-2021 outlines our commitment to a human rights based approach to our work, and a commitment to engage and involve service users and stakeholders, we do not specifically refer to any Section 75 groups. However, our Annual Business Plans over the last five years include objectives and targets relating to Section 75.These refer to actions for service users and their families and carers. There are no other actions specifically aimed at any of the other Section 75 groups.

3.2.2 Policy and decision making, governance and reporting

Equality requirements are broadly integrated in RQIA business planning processes. New programmes of work included in our annual Business Plan emanate from the RQIA Corporate Strategy. Currently the Business Support Manager completes the screening activities for the whole organisation. All new programmes of work have a policy template, which includes an equality section, stating if and when the equality screening was completed.

All new programmes of work go to the RQIA Policy Subgroup, which considers the equality implications of proposed policies. Once policies have been through the Policy Subgroup for commentary, these are then submitted to the Executive Management Team (EMT) for final sign off. However, despite this process, ensuring that screening is carried out on all policies and decisions in a timely manner remains a challenge for the organisation.

Currently, screening templates do not accompany policies and programmes of work for consideration at EMT. Cover pages for papers submitted to the Board do not include detailed information on equality issues identified and how they have been addressed; they do, however , indicate when an equality assessment has been undertaken. Respective leads are not required to provide assurance that an equality screening has been carried out and evidence thereof is publicly available.

The information suggests that at the point of decision-making, EMT members do not have either evidence that the equality issues have been considered appropriately or assurance thereof.

The list of policies screened between 1 April 2016 and 31 March 2021 (see Appendix) shows that

- in total 16 policies were subjected to screening;
- all of these related to corporate affairs, none to specific RQIA functions.

Currently the mechanisms for reporting equality proofing activities are in the RQIA Annual Equality Progress Reports to the Equality Commission.

Lessons Learned:

- Our Corporate Plan does not reference any Section 75 themes, and although statutory duties are referenced in the RQIA Annual Business Plan, currently there is only one objective, relating to carers and families. However this is addressed in the Management Plan 2021-21 which includes a key strategic theme : People and Communities, and through a Styatement of Strategic Intent developed during 2021.
- In relation to new programmes of work a useful governance measure is in place for equality proofing, in that a Policy Subgroup has been established to consider if equality proofing has been adequately completed. This has shown some success in progressing the mainstreaming of equality considerations with regards to corporate affairs. However, equality screening of work to deliver RQIA functions has not yet been carried out. The number of published screenings remains low.
- During the last five years, an RQIA Equality Forum was set up. This met on a quarterly basis. The Forum was formed in 2016 and stood down in March 2018. In the absence of the forum, there is no evidence showing that implementation of Section 75 has been mainstreamed across the organisation.
- The equality screening of the Annual Business Plan offers an important vehicle to develop an annual screening programme at planning stage by identifying a minimum set of key actions in the plan that will need equality screened during the year.
- There is no evidence that equality screenings were carried out in relation to the core functions over the past five years. We also recognise a gap in equality screening of decisions.
- While some further screening activity has been undertaken on the corporate side, there is a gap in ensuring this is documented and published as required.
- Policy documents are not accompanied by screening templates nor do they include summary equality information. Cover papers to the Authority Board do not include an explicit assurance nor summary equality information. At the point of decision-making, EMT and Board members are not provided with evidence or an assurance that the equality issues have been considered appropriately.
- To date, we have not requested information on how equality issues have been considered and informed draft policies that the RQIA receives from our provider of Human Resources services.

Looking ahead:

- We will re-establish the RQIA Equality Forum in order to re-invigorate the Equality agenda throughout RQIA and focus on the commitments within this report. The Forum will include representation from each team and will have a key role in identifying work (particularly relating to the core functions of RQIA) to be equality screened.
- We will include specific equality objectives in future Business Plans. We will highlight key equality objectives in our plan by specifying relevant projects or areas where equality groupings are likely to particularly benefit from the work.
- An annual screening programme will be developed to accompany the Annual Business Plan. This will help to ensure that a minimum set of work planned for the forthcoming year will be equality proofed, particularly for areas of work that directly relate to the functions of RQIA.
- To ensure screening is integrated throughout the organisation, specific equality screening governance processes will be introduced, including:
    - All staff with responsibility for policy or programme development will undertake screening and EQIA training to give them an understanding of the need for equality proofing and the skills required. This will enable staff responsible for different programmes of work to undertake screening themselves to ensure the mainstreaming of equality issues throughout the organisation.
    - All members of the Policy Subgroup will attend both equality screening and Equality Impact Assessment (EQIA) training.
    - We will introduce a cover page for completion by the respective lead to accompany any policy or decision submitted to EMT and Board to include a summary of equality impacts identified in the screening, how these are addressed in the policy or decision, and details on where the completed screening template is publicly available.

3.3 Monitoring and Access to Services

Currently, there is no equality monitoring data collected by RQIA with regard to its functions.

Although the RQIA does not collect or analyse any monitoring information, as part of its inspection process of Mental Health Hospitals and Hospitals for those with a Learning Disability, we encourage services to collect and analyse information on a range of indicators directly related to Section 75. Information is collected from patients and their representatives regarding their experience and views in relation to the indicators below:

- patients can decide who attends any meetings where decisions are made about care and treatment
- staff establish and use their preferred name

- staff listen to and respect their views, opinions and preferences and incorporate these in care and treatment planning and delivery
- they feel included in care and treatment planning, implementation and evaluation
- the need for privacy is respected
- family and friends can visit and are active participants in the recovery processes
- they can keep in touch with other family and friends by phone
- spiritual needs, culture, and values are respected and can be freely expressed

We collect qualitative information from patients and their families to inform inspections. We talk directly to patients and ask them about their experiences. As part of RQIA's ongoing improvement programme, we have distributed posters for permanent display in every care home in Northern Ireland, inviting residents and visitors to contact RQIA at any time with their views on the quality of service being provided. In addition, we have also developed cards that our inspectors leave after every inspection encouraging people to tell us about their personal experiences of the service. This provides RQIA with a unique insight into the care provision and will help inform our inspection reports and our assurance and quality improvement activities. However, there is no equality monitoring data gathered as part of this work.

Each day we have an inspector on duty responding to calls from service providers and the public. During the last year we received over 2,350 calls – almost 900 from members of the public wishing to discuss queries or concerns about care service. However, with no equality monitoring data collected, we don't know which groups are more likely to use our services, and more importantly, if there are any Section 75 groups who are less likely to use our services (e.g. ethnic minority groups, people of different sexual orientation etc.)

With regard to staff equality data, completion of the equality and diversity information on the Human Resources (HR) system is voluntary and whilst staff are encouraged to do so, completion rates are particularly low in relation to the categories of dependants, disability, sexual orientation, political opinion, and ethnicity.

More robust staff data is necessary to inform the equality screening of relevant policies and decisions.

Lessons Learned:

- The quality of the equality data that we need to draw on for our work has significant limitations. Although we encourage services to consider equality issues in indicators for the delivery of safe, effective and compassionate person centred services, services we inspect do not collect information on our behalf relating to individual patients' Section 75 characteristics.

- We have no way of telling if outcomes and service satisfaction vary across different groups e.g. transgender, gay, lesbian bisexual patients, ethnic minority groups etc.
- There is no evidence to suggest that the collection and use of equality monitoring data for all nine categories has been mainstreamed across all RQIA functions.

Looking Ahead:

- We will further encourage staff to complete equality and diversity information to strengthen the data, eg. on disability.
- We will work with service providers to develop a more robust monitoring system to reflect the breakdown of people who are using services we inspect. We will develop a series of impact questions to be included in the provider post questionnaire to explore what Section 75 characteristics providers capture to allow us to monitor what information is being collected.
- We will ask service providers to share this information with us, in order that we can then look at the data to gauge if patients from any of the Section 75 groups have a different experience of the services we inspect.

3.4 Engagement

RQIA involves various groups and individuals in a range of aspects of our work.

In our 2017-21 Corporate Strategy we commit to:

- engage service users and stakeholders in the co-design of our interventions (audit, review, inspection and investigations);
- involve service users as part of inspections and reviews, and;
- enable and encourage service users and the public to provide the intelligence needed to inform assurance and improvement activity.

We developed a Communications and Engagement Strategy in 2018/2019, which provides opportunities for us to engage with stakeholders, including service users and the general public. This has helped shape and inform the design of our Review Programme.

The RQIA has had regular engagement with voluntary sector organisations and advocacy groups representing:

- those with learning, sensory and physical disabilities, and mental health issues (e.g. the Cedar Foundation; Dementia NI, Aware NI, Inspire, and Lifeline etc.).
- people of different ages (e.g. Commissioner for Older People (COPNI); National Society for the Prevention of Cruelty to Children (NSPCC); Voices of Young People in Care (VOYPIC) etc.);
- different political backgrounds (in our meetings with NI political parties/ representatives)

- dependants (National Childbirth Trust, Sure Start, Mother's Voice, CAUSE[2])

This gives RQIA an important insight into the priorities for these different groups, and an opportunity to hear about current issues and what their members are saying. This allows us to identify gaps in services.

A number of years ago, we had established relationships with voluntary organisations supporting ethnic minority groups (Northern Ireland Council for Ethnic Minority Groups (NICEM), and gay, lesbian and bisexual people (The Rainbow Project). However, over the last five years, it is recognised these relationships have weakened, and work needs to be done to re-energise these.

RQIA regularly uses peer reviewers, who bring a wealth of experience and knowledge from across the health and social care sector. This has included providing induction training for the Northern Ireland Medical and Dental Training Agency's (NIMDTA) Clinical Trainee Associates to join our inspection teams in our acute hospital inspection programme.

RQIA involves service users and members of the public as volunteer lay assessors. For example, we attend Pensioners Parliaments[3] in each council area across Northern Ireland. At each event which supported engagement with service users and the wider public we spoke with attendees, provided information on our work, and encouraged involvement in lay assessor roles.

We also developed an engagement programme with members of the public, including "Open House" events at RQIA's offices. At these events members of the public had an opportunity to speak directly to our senior management team and acting Chair about aspects of our work; and find out how they can get involved. These events were promoted through social media channels, newspapers and with support from partner organisations including Age Sector Platform, Age NI, and VOYPIC.

Restrictions in care home visiting during the Covid-19 pandemic impacted on RQIA's opportunities to meet face-to-face with the family members of those in health and social care services. However, RQIA continued to encourage the public to contact its Guidance Team by telephone or email, where they had queries or concerns relating to their loved one's care.

During 2020, RQIA in partnership with the Patient and Client Council, the HSC Board and Public Health Agency, established a platform to strengthen engagement and build relationships with relatives of people living in care homes. On a weekly basis, relatives and their representative organisations have an opportunity to discuss concerns in relation to care and visiting and care partner arrangements.

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[2] CAUSE is an advocacy group supporting carers of people with a mental illness.
[3] These parliaments provide older people from across Northern Ireland with a local forum to discuss their concerns.

These video meetings are also attended by representatives from the Commissioner for Older People Northern Ireland, Age NI and the Alzheimer's Society, and Care Home Advice Support Northern Ireland.

As a member of the Equality Forum of the 11 regional HSC organisations, RQIA has access to Section 75 groups via its consultation database, which has been used to consult with on the development of Human Resources policies, e.g. Gender Identity Employment Policy.

RQIA also has access to other HSC staff forums, such as the HSC Forum for gay, lesbian, bisexual and transgender staff, and Tapestry, the Disability Staff Forum, to engage and consult with on a range of employment and service issues. To date, neither of these staff groups have been approached as a matter of course in the development of Human Resources policies.

Lessons Learned:

- Where we offer opportunities for individuals to be involved in our work, we do not currently know which equality groupings the individuals belong to. Without this information and without targeting any particular equality groupings to encourage them to become involved we cannot be sure that we hear a diverse range of voices.
- Although we have established good working relationships with voluntary organisations supporting those with a range of disabilities, people of different ages, different political backgrounds, and dependants, we have more work to do to engage fully with other Section 75 groups (i.e. sexual orientation, ethnic minorities).
- While dedicated staff forums on disability, sexual orientation and gender identity exist within the HSC, these have not been engaged with in the development of Human Resources policies as a matter of course.

Looking Ahead:

- In order to better gauge how diverse the voices are that we hear in our engagement we will pilot collecting equality/diversity information on a voluntary basis in the following areas:
    - public engagement activities and consultations to inform our work, including input into the development of our Review Programmes;
    - recruitment of lay assessors who will bring their own experience, fresh insight and a public focus to our inspections and reviews, and;
    - recruitment of peer reviewers
- We will seek assurance from our provider of Human Resources services that engagement with the existing staff forums has been undertaken for any policies they develop on our behalf.
- We have commenced the development of a communications and engagement strategy, based on the principles of co-production and co-design, with

involvement of HSC and independent providers and service users and the wider public in partnership with the Patient and Client Council.

3.5 Ensuring RQIA staff assist the organisation in implementing Section 75

The new regional HSC template for Job Descriptions and Personnel Specifications no longer makes reference to the Section 75 duties. However, all existing RQIA job descriptions include a general requirement to comply with Equality duties. RQIA Job Descriptions and Personnel Specifications state: “To assist the Authority in fulfilling its statutory duty under Section 75 of the Northern Ireland Act 1998 to provide equality of opportunity and the promotion of good relations.”

Over the past five years, RQIA has put arrangements in place to ensure that staff complete equality training. This includes regular reporting to EMT regarding the numbers of staff who have completed mandatory training. Staff who have not competed the necessary training are followed up.

- Completion of the Making a Difference[4] equality e-learning programme is mandatory for all RQIA staff (Part 1 for all staff, Part 2 for line managers).This training is one of our actions within our Equality and Disability Action Plans.
- Compliance with all mandatory e-learning programmes is monitored by line managers and updates provided to our EMT on a regular basis. This has proven effective, given that as at 31st March 2021, 111 RQIA staff had completed Making A Difference training.
- However, the numbers of staff attending training sessions on Equality Screening and Equality Impact Assessment (EQIA) training is lower. 12 RQIA staff attended Equality Screening, and no-one attended EQIA Training during the five year period up to 31st March 2021.

In addition to this, bespoke update sessions and consultancy from the Equality Unit has been organised for RQIA staff. Over the last 5 years this has included training on Reasonable Adjustments for staff with disabilities; deaf awareness training; training on the Good Relations duty, and; training on How to Get that Job for participants of the Disability Placement Scheme placed within the RQIA. In addition to training with staff, RQIA Authority board members took part in an Equality Scheme briefing.

[4] The programme was developed jointly by all HSC organisations. Prior to the introduction of this, it had been mandatory for staff to undertake the Discovering Diversity eLearning, again a bespoke package, developed in-house.

Lessons Learned:

- Reference to the Section 75 duties in all Job Descriptions is essential to ensure all staff have responsibility for mainstreaming equality in the organisation.
- We recognise a gap exists in ensuring that senior decision-makers are fully trained on equality screenings and EQIAs.

Looking Ahead:

- All senior decision-makers will undertake training on equality screening and EQIA within two years.
- A new definition of "relevant staff" who are to undertake equality screening and EQIA training will be introduced. This will be based on staff bandings (band 5 and above) as a minimum set, with Directors responsible for identifying additional staff in need of the training.
- We will seek assurance from our provider of Human Resources services that reference to the Section 75 duties is reintegrated into the template used for all new Job Descriptions.

3.6 Leadership

Over the last five year period, the RQIA Authority board members received training on Equality and Diversity, and an Equality Scheme briefing.

Currently, the RQIA Authority board meetings do not include equality as a standing agenda item. The Business Support Unit is the equality lead and acts as the main driver for the equality agenda in RQIA. RQIA also is an active participant in the HSC Equality Forum facilitated by BSO's Equality Unit, who meet on a quarterly basis to share good practice in the implementation of Section 75 and to plan joint work. At a strategic level, the BSO's Equality Unit represents member organisations on a number of regional groups, reporting back to the Forum as and where required.

Members of the EMT are involved in Section 75 implementation through annual progress reporting, receiving and approving progress reports and direction setting for the coming year.

Senior managers play an important role by:

- contributing to annual progress reporting by identifying relevant initiatives in their area of responsibility, and
- ensuring training attendance of relevant staff.

RQIA's Communications Manager is an active member of the Disability Champions Network. This is a group of HSC Directors and Board members who seek to influence and change everyday practices relating to disability issues within the regional HSC organisations.

Implementation of the Equality and Disability Action Plans is primarily managed by the Business Support Unit, but individual actions require participation and involvement of all staff across the organisation.

Visibly promoting and celebrating diversity constitutes a further key aspect of active leadership on Section 75 implementation. For example, two disability awareness days are organised each year and all staff are encouraged to participate in these, read information provided, attend information sessions etc. Details of the HSC Tapestry Disability Staff Forum are also shared with staff, who are encouraged and facilitated to attend meetings within their working day.

Lessons Learned:

- Active Section 75 implementation over the last five years has largely been led by the Business Support Unit within the organisation. While this may be a good fit from a reporting and governance angle, it is essential to widen the active ownership of the equality and diversity agenda through further mainstreaming equality in RQIA core business.
- Working in close partnership with the other 10 regional HSC organisations through the HSC Equality Forum produces important benefits for small organisations in particular, including access to resources and prompts on deadlines. Likewise, awareness of progress across partner organisations can strengthen arguments of the need to bring about progress in one's own organisation. There remains scope for strengthening of sharing of good practice across the forum to enable the organisations to learn from each other.

Looking Ahead:

- Over the next five years, we will widen our efforts to draw attention and implement good practice in equality and diversity issues, particularly relating to ethnicity, sexual orientation and gender identity.
- We will highlight and demonstrate our commitment to the equality and diversity agenda to new leaders, such as Board members, when they join, including through training.
- Currently, the RQIA Authority Board does not include equality as a standing agenda item. We will change this in order to ensure equality issues are driven from the top of our organisation.
- Similarly, going forward, EMT will include equality issues as a standing agenda item.
- The HSC Equality Forum will dedicate more time to the sharing of good practice initiatives at its quarterly meetings.

4. Conclusions

4.1 How has the scheme's implementation benefitted individuals within the Section 75 groups?

In relation to the workplace, RQIA has made progress in identifying and seeking to address the needs of staff who have caring responsibilities. Staff awareness days have proved to be effective in increasing awareness, knowledge and skills of staff and line managers in meeting the needs of colleagues with a particular disability. In addition, Tapestry has given a platform to staff who have a disability to raise and discuss disability issues in a safe environment.

For service users, we have adopted a targeted approach as part of inspections to get providers to account for S75 in developing and delivering services, and awareness raising of key equality issues. This has been reflected in inspection reports.

Work to date includes positive outcomes for elderly people and those with a brain injury, as well as Supporting Families and Dementia Care in Northern Ireland, with carers and trust staff from across Northern Ireland sharing examples of best practice, including Dementia Champions Model and the Patient Centred Model.

4.2 How are leaders within the authority engaged in the scheme's implementation?

Currently, the RQIA Authority Board meetings do not include equality as a standing agenda item. The Business Support Unit acts as the main driver for the equality agenda in RQIA. RQIA also is an active participant in the HSC Equality Forum facilitated by BSO's Equality Unit, who meet on a quarterly basis to share good practice in the implementation of Section 75 and to plan joint work. At a strategic level, the BSO's Equality Unit represents member organisations on a number of regional groups, reporting back to the Forum as and where required.

Members of the EMT are involved in Section 75 implementation through annual progress reporting to the ECNI.

Senior managers play an important role by:

- contributing to annual progress reporting by identifying relevant initiatives in their area of responsibility, and
- ensuring training attendance of relevant staff.

4.3 Challenges and how they have been overcome

The key challenge over the past five years was the integration of equality considerations in all core work of the organisation, which in many ways is the key challenge in implementing Section 75 overall. Whilst it cannot be argued therefore that this challenge was overcome during the period covered by the review, important progress has been made, first and foremost by:

- Engaging with service users to establish what their needs are in relation to RQIA and processes.
- Engaging with advocacy organisations to be aware of the main issues for people with learning, sensory and physical disabilities, and carers, in accessing health and social care services that meet their needs.

4.4 Lessons Learned

(1) Outcomes

- By engaging with patients and service users, we have heard first-hand about their experiences, and can then make recommendations for service improvement.
- We recognise that individuals can fall into more than one equality category. Although we have published a number of reviews over the last five years relating to Section 75 groups, these have not examined diversity within each of these categories. For example, although the Review of Perinatal Mental Health Services in NI aims to improve services for women, it does not consider the diversity within this group. For example, women from different ethnic minority groups or women with disabilities may experience different needs with regards to help-seeking, accessing and utilising services.
- Working in partnership with advocacy organisations has produced positive outcomes for certain Section 75 groups. For example, work with VOYPIC and care experienced young people to allow our inspectors to refine our inspections of children's homes. However, again we recognise that there is no evidence that the diverse needs of young people in care are met through our inspections.
- Also, work with Action on Hearing Loss, RNIB (Royal National Institute for the Blind), Carafriend and other groups supporting people of different sexual orientations has raised awareness of parts of the community that are often invisible, and highlighted to us that we need to be aware of those who have different needs and expectations.
- We have made improvements to our information materials (both in terms of our reports, and corporate information such as how to make a complaint)

through the production of easy read formats in order to facilitate the needs of those with learning disabilities.

- We have commenced work on our assurance framework which will include work to simplify and improve the accessibility of our inspection reports, in partnership with service users, carers and their families. Through our communications and engagement strategy, using co-production and co-design principles we will involve the public in shaping improvements to our website.

(2) Business Planning, Policy- and Decision-Making, and Governance

- Our Corporate Plan does not reference any Section 75 themes, and although statutory duties are referenced in the RQIA Annual Business Plan, currently there is only one objective, relating to carers and families.
- In relation to new programmes of work a useful governance measure is in place for equality proofing, in that a Policy Subgroup has been established to consider if equality proofing has been adequately completed. This has shown some success in progressing the mainstreaming of equality considerations with regards to corporate affairs. However, equality screening of work to deliver RQIA functions is not carried out. The number of published screenings remains low.
- During the last five years, an RQIA Equality Forum was set up. This met on a quarterly basis. This Forum was formed in 2016 and stood down in March 2018. In the absence of the forum, there is no evidence showing that implementation of Section 75 has been mainstreamed across the organisation.
- The equality screening of the Annual Business Plan offers an important vehicle to develop an annual screening programme at planning stage by identifying a minimum set of key actions in the plan that will need equality screened during the year.
- There is no evidence that equality screenings were carried out in relation to the core functions over the past five years. We also recognise a gap in equality screening of decisions.
- While some further screening activity has been undertaken on the corporate side, there is a gap in ensuring this is documented and published as required.
- Policy documents are not accompanied by screening templates nor do they include summary equality information. Cover papers to RQIA's Authority Board do not include an explicit assurance nor summary equality information. At the point of decision-making, EMT and Authority Board members are not provided with evidence or assurances that the equality issues have been considered appropriately.
- To date, we have not requested information on how equality issues have been considered and informed draft policies that the RQIA receives from our provider of Human Resources services.

(3) Monitoring, Access to Information and Services

- The quality of the equality data that we need to draw on for our work has significant limitations. Although we encourage services to consider equality issues in indicators for the delivery of safe, effective and compassionate person centred services, services we inspect do not collect information on our behalf relating to individual patients' Section 75 characteristics. We have no way of telling if outcomes and service satisfaction vary across different groups e.g. transgender, gay, lesbian bisexual patients, ethnic minority groups etc.
- There is no evidence to suggest that the collection and use of equality monitoring data for all nine categories has been mainstreamed across all RQIA functions.

(4) Engagement

- Where we offer opportunities for individuals to be involved in our work, we do not currently know which equality groupings the individuals belong to. Without this information and without targeting any particular equality groupings to encourage them to become involved we cannot be sure that we hear a diverse range of voices.
- Although we have established good working relationships with voluntary organisations supporting those with a range of disabilities, people of different ages, different political backgrounds, and dependants, we have more work to do to engage fully with other Section 75 groups (i.e. sexual orientation, ethnic minorities).
- While dedicated staff forums on disability, sexual orientation and gender identity exist within the HSC, these have not been engaged with in the development of Human Resources policies as a matter of course.

(5) Ensuring staff assist the organisation in implementing Section 75

- Reference to the Section 75 duties in all Job Descriptions is essential for making equality everybody's business in the organisation.
- We recognise a gap in ensuring that senior decision-makers are fully trained on equality screenings and EQIAs.

(6) Leadership

- Active Section 75 implementation over the last five years has largely been led by the Business Support Unit within the organisation. While this may be a good fit from a reporting and governance angle, it is essential to widen the active ownership of the equality and diversity agenda through further mainstreaming equality in RQIA core business.
- Working in close partnership with the other 10 regional HSC organisations through the HSC Equality Forum produces important benefits for small organisations in particular, including access to resources and prompts on deadlines. Likewise, awareness of progress across partner organisations can strengthen arguments of the need to bring about progress in one's own

organisation. There remains scope for strengthening of sharing of good practice across the forum to enable the organisations to learn from each other.

4.5 Going Forward

(1) Outcomes

- In relation to our workforce we will devote more attention to the needs of our staff who are carers. We will also raise awareness of the HSC Staff Network supporting staff of different sexual orientations and gender identities and Tapestry, the HSC Staff Disability Network. This will not only raise visibility and awareness of these groups, but will also support staff within these Section 75 categories.
- We will work with the other regional organisations and BSO to ensure that the design specifications for new systems relating to HR, Finance and Procurement as well as any new eLearning programmes meet accessibility standards in order to meet the needs of staff and candidates with different disabilities.
- We will look at gaps in certain work programmes. For example, inspections of Domiciliary Care and Care Homes for Older People will include consideration of the needs of other Section 75 groups. This will initially focus on sexual orientation and gender, in line with DoH Guidance “See Me, Hear Me, Know Me” aiming to support the needs of older lesbian, gay, bisexual and transgender people in nursing, residential, and day care settings and those who live at home and receive domiciliary care.
- Several of our inspection reports on health and social care provision in criminal justice institutions have already highlighted gaps in relation to consideration of the needs service users of different sexual orientations. We will work with voluntary organisations, service providers, and our partners in the PHA and Justice sector to meet the needs of those of different sexual orientations.

(2) Business Planning, Policy and Decision-Making, and Governance

- We will include specific equality objectives in future Business Plans. RQIA’s Management Plan 2021-22 includes a key strategic theme focusing on People and Communities, which states: We will work as partners with the public, people who use and provide services and our own staff to deliver a modern and responsive regulatory system that supports the delivery of safe and effective care and safeguards people’s rights. We will highlight key equality objectives in our plan by specifying relevant projects or areas where equality groupings are likely to particularly benefit from the work.
- An annual screening programme will be developed to accompany the Management Plan (RQIA’s Annual Business Plan). This will help to ensure that a minimum set of work planned for the forthcoming year will be equality proofed, particularly for areas of work that directly relate to the functions of RQIA.

- To ensure screening is integrated throughout the organisation specific equality screening governance processes will include:
    - All staff with responsibility for policy or programme development will undertake screening and EQIA training to give them an understanding of the need for equality proofing and the skills required. This will enable staff responsible for different programmes of work to undertake screening themselves to ensure the mainstreaming of equality issues throughout the organisation.
    - All members of the Policy Subgroup will attend both equality screening and Equality Impact Assessment (EQIA) training.
    - We will introduce a cover page for completion by the respective lead to accompany any policy or decision submitted to EMT and Board to include a summary of equality impacts identified in the screening, how these are addressed in the policy or decision, and details on where the completed screening template is publicly available.
- We will re-establish the RQIA Equality Forum in order to reinvigorate and place a clear focus on the Equality agenda throughout RQIA. The Forum will include representation from each team and will have a key role in identifying work (particularly relating to the core functions of RQIA) to be equality screened.

(3) Monitoring, Access to Information and Services

- We will further encourage staff to complete equality and diversity information to strengthen the data, eg. on disability.
- We will work with service providers to develop a more robust monitoring system to reflect the breakdown of people who are using services we inspect. We will develop a series of impact questions to be included in the provider post questionnaire to explore what Section 75 characteristics providers capture to allow us to monitor what information is being collected.
- We will ask service providers to share this information with us, in order that we can then look at the data to gauge if patients from any of the Section 75 groups have a different experience of the services we inspect.

(4) Engagement

- RQIA has currently commenced a new Communications and Engagement Collaborative involving a wide range of stakeholders which will support the development of a new Communcations and Engagement Strategy for RQIA, placing a clear focus on engagement and partnership.
- In order to better gauge how diverse the voices are that we hear in our engagement we will pilot collecting equality/diversity information on a voluntary basis in the following areas:
    - public engagement activities and consultations to inform our work, including input into the development of our Review Programmes;
    - recruitment of lay assessors who will bring their own experience, fresh insight and a public focus to our inspections and reviews, and;

    - recruitment of peer reviewers
- We will seek assurance from our provider of Human Resources services that engagement with the existing staff forums has been undertaken for any policies they develop on our behalf.

(5) Ensuring staff assist the organisation in implementing Section 75

- All senior decision-makers will undertake training on equality screening and EQIA within two years.
- A new definition of “relevant staff” who are to undertake equality screening and EQIA training will be introduced. This will be based on staff bandings (band 5 and above) as a minimum set, with Directors responsible for identifying additional staff in need of the training.
- We will seek assurance from our provider of Human Resources services that reference to the Section 75 duties is reintegrated into the template used for all new Job Descriptions.
- RQIA’s re-established Equality Forum will ensure a clear focus is placed on the Equality agenda at all levels within RQIA, and will report progress regularly to RQIA Executive Management Team.

(6) Leadership

Over the next five years, we will widen our efforts to draw attention and implement good practice in equality and diversity issues, particularly relating to ethnicity, sexual orientation and gender identity.

- We will highlight and demonstrate our commitment to the equality and diversity agenda to new leaders, such as Authority board members, when they join, including through training.
- Currently, the RQIA Authority board meetings do not include equality as a standing agenda item. We will change this in order to ensure equality issues are driven from the top of our organisation.
- Similarly, going forward, EMT will include equality issues as a standing agenda item in meetings.
- The HSC Equality Forum will dedicate more time to the sharing of good practice initiatives at its quarterly meetings.

Appendix: List of policies equality screened from 1 Apr 2016 to 31 Mar 2021

Year	Policy Title	Decision
2016-17	Proposal for Recurrent Savings 2016-17, Regulation Directorate	Screened out with mitigation
2016-17	Consultation on RQIA's Corporate Strategy 2017-21 and Screening	Screened out with mitigation
2016-17	Secondment Guidelines	Screened out with mitigation
2017-18	Zero Tolerance Policy	Screened out with mitigation
2017-18	Post Entry Training Policy	Screened out with mitigation
2017-18	Attendance at Work Policy	Screened out with mitigation
2017-18	Tapestry Communication and Information Screening	Screened out with mitigation
2017-18	Anti Fraud Policy	Screened out with mitigation
2017-18	Whistleblowing Policy	Screened out without mitigation
2017-18	Capability Procedure	Screened out with mitigation
2017-18	Disciplinary Procedure	Screened out with mitigation
2017-18	Consultation on Equality and Disability Action Plans 2018-23	Screened out with mitigation
2018-19	Leave Pack	Screened out with mitigation
2018-19	Family Pack	Screened out with mitigation
2019-20	Conflict Bullying and Harassment in the Workplace	Screened out with mitigation

2019-20	Records Management Policy	Screened out without mitigation