The Regulation and Quality Improvement Authority

AGENDA

RQIA Board Meeting
Boardroom, RQIA
Thursday 21 November 2019, 11.45am

PUBLIC SESSION

1	Minutes of the public meeting of the Board held on Thursday 26 September 2019 and matters arising	Min/Sept19/ public	11.45am **APPROVE**
2	Declaration of Interests		11.50am
3	Acting Chair's Report **Acting Chair**	F/09/19	11.55am **NOTE**
	STRATEGIC ISSUES		
4	Corporate Performance Report (Quarter 2) **Head of Business Support**	G/09/19	12.05pm **APPROVE**
5	Corporate Risk Assurance Framework Report **Head of Business Support**	H/09/19	12.15pm **APPROVE**
6	Records Management Policy **Head of Business Support**	I/09/19	12.25pm **APPROVE**
7	RQIA Finance Update **Head of Business Support**	J/09/19	12.35pm **NOTE**
	OPERATIONAL ISSUES		
8	IRRS Mission **Assistant Director of Improvement & Senior Inspector, IHC**		12.45pm **NOTE**
9	Chief Executive's Report **Chief Executive**	K/09/19	13.05pm **NOTE**
10	Audit Committee Business **Chair of Audit Committee** • Approved minutes of meeting on 14 June 2019 • Verbal update on meeting on 17 October 2019 • RQIA Mid-Year Assurance Statement	L/09/19	13.15pm **NOTE**

11	Board Self-Assessment **Acting Chair**	M/09/19	13.25pm **APPROVE**
12	Any Other Business		13.30pm

Date of next meeting: 16 January 2019, Boardroom, RQIA

The Regulation and Quality Improvement Authority

RQIA Board Meeting

Date of Meeting	21 November 2019
Title of Paper	Public Session Minutes
Agenda Item	1
Reference	Min / Sept19 / public
Author	Hayley Barrett
Presented by	Prof. Mary McColgan
Purpose	To provide Board members with a record of the previous meeting of the RQIA Board.
Executive Summary	The minutes contain an overview of the key discussion points and decisions from the Board meeting on 26 September 2019
FOI Exemptions Applied	None
Equality Impact Assessment	Not applicable
Recommendation/ Resolution	The Board is asked to **APPROVE** the minutes of the Board meeting on 26 September 2019
Next steps	The minutes will be formally signed off by the Chair.

PUBLIC SESSION MINUTES

RQIA Board Meeting **Boardroom, RQIA** **26 September 2019; 11.45am**	
Present Prof. Mary McColgan OBE ***(MMcC)*** Lindsey Smith ***(LS)*** Denis Power ***(DP)*** Robin Mullan ***(RM)*** Seamus Magee OBE ***(SM)*** Patricia O'Callaghan ***(POC)*** **Apologies** Sarah Havlin ***(SH)*** Dr Norman Morrow ***(NM)*** Gerry McCurdy ***(GMcC)***	**Officers of RQIA in attendance** Olive Macleod OBE (Chief Executive) ***(OM)*** Dr Lourda Geoghegan (Director of Improvement and Medical Director) ***(LG)*** Theresa Nixon (Director of Assurance) ***(TN)*** Jennifer Lamont (Head of Business Support) **(JL)** Hayley Barrett (Business Manager) (**HB)**

1.0 Welcome and Apologies

1.1 MMcC welcomed all members and Officers of the Board to this meeting. Apologies were noted from Sarah Havlin, Gerry McCurdy and Norman Morrow.

2.0 Agenda Item 1 – Minutes of the public Board meeting held on 4 July and matters arising

2.1 Board members **APPROVED** the minutes of the Board held on Thursday 4 July.

2.2 Board members noted that actions 207 and 208 are now complete. Action 201 and 204 are ongoing.

2.3 MMcC advised that action 204 would be deferred until January 2020.

2.4 LG provided an update in relation to action 201. LG advised that following an inspection of NIAS sufficient assurances were not received. Following a serious concerns meeting the Improvement Notices have been extended to 31 March 2020. It is anticipated that NIAS would be invited to a meeting of the Board in 2020 when compliance has been achieved.

2.5 Board members agreed that action 201 can be removed.

3.0 Agenda Item 2 –Declaration of Interests

3.1 MMcC asked Board members if, following consideration of the agenda items, any interests were required to be declared in line with Standing Orders. RM advised that he is a member of the Equality Commission.

4.0 Agenda Item 3 – Presentation – Using Information and Intelligence Effectively - RQIA's Improvement Journey

4.1 MMcC advised that the presentation – Using information and Intelligence Effectively – RQIA's Improvement Journey would be deferred.

5.0 Agenda Item 4 – Acting Chair's Report

5.1 MMcC advised Board members of a NICON Leadership and Governance Conference on 27 November. MMcC, DP, GMcC and NM will be in attendance.

5.2 MMcC advised of a NI Public Sector Chairs Forum on 8 October that DP will represent RQIA.

5.3 MMcC advised of a meeting with the CPEA Reference Group on 1 October with a specific focus on Adult Safeguarding.

5.4 MMcC advised of meeting attended since the last meeting of the Board with IHRD RQIA Remit Sub Group, NISCC and PCC.

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

6.0 Agenda Item 5 – RQIA Communications and Engagement Strategy

6.1 JL advised Board members that this strategy outlines the principles of communication and engagement and the purpose is to support the work of the business plan and directorate business plans.

6.2 JL advised Board members that RQIA have rebranded promotional materials which will launch on 10 October at RQIA's Open House Event. The new material was presented to the Board and it was agreed the format was more user friendly.

6.3 JL updated Board members in relation to internal communications with staff including: newsletter, EMT and team meeting feedback.

6.4 JL advised that we are engaging with the media, using social media and that the membership scheme will be relaunched.

6.5 Board members acknowledged the content of the strategy and agreed with the principles of communication and engagement. LS queried how we are making it less formal for staff / clients to interact with us. JL advised that we are

listening to what people want and acting on it as far as we can. It was agreed that the Strategy would be reviewed at a meeting of the Board during 2020-21.

6.6 Board members **APPROVED** the RQIA Communications and Engagement Strategy.

6.7 JL advised that all Board members are welcome to the Open House Event on 10 October 2019 in RQIA.

7.0 Agenda Item 6 – Mental Capacity Act (2016)

7.1 JL advised that the Mental Capacity Act (2016) partial implementation has been deferred to 1 December.

7.2 JL informed Board members that the Chief Executive has chaired a weekly internal meeting with the Executive Team, Senior Staff and Inspectors relating to the implementation and the impact on RQIA.

7.3 Board members noted that the view is that this implementation will be business as usual. JL advised that the weekly meetings have highlighted that there are similarities in the role of RQIA but some differences.

7.4 JL added that the Mental Health Order (1986) will run in parallel with the Mental Capacity Act (2016) for the meantime.

7.5 JL advised that each Trust will have a list of approved professionals with training provided by DoH to be members of panels.

7.6 Board members acknowledged that the implications on RQIA are more than what was expected.

7.7 Board members **NOTED** the Mental Capacity Act (2016) update.

8.0 Agenda Item 7 – SOAD Policy and Procedure

8.1 LG advised that the Part II Policy and Procedure was revised in January 2019. The SOAD Policy and Procedure has been amended to reflect similar amendments to the process of appointments. LG advised that the policy would be in effect from 1 October, following approval, and will be circulated to Panel members.

8.2 OM left the meeting at this point.

8.3 Board members **APPROVED** the SOAD Policy and Procedure.

9.0 Agenda Item 8 – Chief Executive's Report

9.1 JL advised Board members that the legal action relating to the death of Ms Kathleen Fegan has been settled and RQIA's liability has been confirmed.

9.2 JL advised that the DoH requested that RQIA declare any financial pressures; RQIA did not declare any pressures and have accounted for a 1% pay uplift in our budget forecast.

9.3 DP requested a finance update paper is presented to Audit Committee on 17 October.

9.4 **Resolved Action (209)**
Finance update paper to be presented to Audit Committee on 17 October.

9.5 JL provided an update on the EU Exit preparedness that RQIA have been in attendance at all DoH planning meetings and there is currently no risk for RQIA.

9.6 TN advised Board members that RQIA have been engaging with the Trusts on the development of Monthly Monitoring Report templates. Three improvement workshops for children's services providers have been organised for 21, 22, and 23 October.

9.7 Board members noted the enforcement action since the last meeting. TN advised that areas of improvement relate to staffing, governance arrangements and medicines management.

9.8 LG advised of 11 serious concerns / Intention to Serve meetings with Trusts / Providers and progress meetings.

9.9 LG advised that three referrals to the GDC have been made in relation to one dental practice.

9.10 LG advised that in relation to online prescribing (Independent Medical Agencies (IMAs) the Care Quality Commission (CQC) is hosting a meeting to address the issues. All four countries are involved and a short statement has been developed and agreed.

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

10.0 Agenda Item 9 – Equality and Disability Annual Report

10.1 Board members **NOTED** the Equality and Disability Annual Report.

10.2 DP queried if RQIA receive feedback comments from the equality commission following submission of the report. MF advised that he would follow up with BSO Equality Unit in relation to feedback.

11.0 Agenda Item 10 – Any other business

11.1 As there was no other business, MMcC thanked Board members and Officers for their attendance and contribution and brought the meeting to a close.

Date of next meeting:
21 November 2019

Signed _____

Professor Mary McColgan
Acting Chair

Date _____

Board Action List

Action number	Board meeting	Agreed action	Responsible Person	Date due for completion	Status
209	26 September 2019	Finance update paper to be presented to Audit Committee on 17 October.	Head of Business Support	17 October 2019	

Key

Behind Schedule	
In Progress	
Completed or ahead of Schedule	

The Regulation and Quality Improvement Authority

RQIA Board Meeting

Date of Meeting	21 November 2019
Title of Paper	Acting Chair's Report
Agenda Item	3
Reference	F / 09 / 19
Author	Prof. Mary McColgan
Presented by	Prof. Mary McColgan
Purpose	To inform the RQIA Board of external engagements and key meetings since the last Board meeting of RQIA.
Executive Summary	External engagements and key meetings since the last Board meeting of RQIA.
FOI Exemptions Applied	None.
Equality Impact Assessment	Not applicable.
Recommendation/ Resolution	The Board is asked to **NOTE** this report.
Next steps	Not applicable.

ACTING CHAIR'S REPORT FOR RQIA BOARD ON 21 NOVEMBER 2019

1. Deprivation of Liberty (DoL) workshop for Board on 24 October was informative and the opportunity to engage with RQIA staff directly involved in mental health aspects was beneficial as it enhanced Board members awareness of the challenges posed for the sector when the new legislation is introduced.

2. Patient Client Council (PCC) held a 10 year celebration in Belfast City Hall on 23 October. I attended with CEO and the event focused on their achievements placing service users and carers at the centre of their work, as well as a presentation about co-design and co-production. Vivian McConvey, CEO outlined their strategic direction highlighting the benefits of working in partnership with other organisation. It is likely that RQIA will develop closer relationship with PCC in future.

3. IHRD Board Effectiveness work stream met on 22 October in Mossley Mill. In addition to reviewing progress on the recommendations, particular attention was paid to the development of the Handbook for NED's. I will participate in a Task and Finish Group to complete work on this. The handbook outlines the core roles and responsibilities of NEDs, a suggested induction programme, useful resources and uses case studies to illustrate some of the challenges faced in the governance and monitoring role. It is anticipated that the handbook will be a 'live document' subject to ongoing review.

4. RADaR presentation was provided to CPEA and members of Sponsor Branch on 21 October to disseminate information about the project, illustrate how it works in practice to support regulation and inspection and demonstrate how its evidence based approach will enhance RQIA work. Professor Taylor was also present to explain the origins of the project and its relationship to understanding how risk models could assist development of a structured EBP approach.

5. Interviewing for Director of Assurance involved meetings on 18 October, 21 October and 28 October

6. RQIA held several roadshows for providers to highlight the regulation and inspection process, the key themes emerging from inspections and the progress and development of a new methodology. I attended a workshop in Omagh on 15 October alongside a range of private health care providers. The inputs from RQIA staff were welcomed and formal feedback confirms how valuable the sector finds this engagement.

7. RQIA's first Open Day held on 10 October was a very successful event. The informality and opportunity to meet with senior staff as well as individual inspectors contributed to raising awareness of RQIA's work. The Business Support staff are to be congratulated for organising the event, feedback confirms the benefits and future events will build on this successful venture.

8. Gerry Mc Curdy, Dr Norman Morrow and I attended 'The Role of the NED' held at Dunadry on 9 October.

9. Rescheduled Meeting with COPNI was held on 8 October.

10. Attended appraisal meeting with CMO on 24 October.

MEETINGS ATTENDED BY NON-EXECUTIVE DIRECTORS
None.

Mary McColgan
Acting Chair
12 November 2019

The Regulation and Quality Improvement Authority

RQIA Board Meeting

Date of Meeting	21 November 2019
Title of Paper	Corporate Performance Report, Quarter 2
Agenda Item	4
Reference	G/09/19
Author	Business Manager
Presented by	Head of Business Support
Purpose	The purpose of the Corporate Performance Report is to provide evidence to the Board on how well RQIA is delivering the actions identified within the annual Business Plan aligned to the four strategic themes in the Corporate Strategy 2017-21. The report presents a **cumulative** picture of corporate performance and summarises key achievements and issues.
Executive Summary	By the end of Quarter 2, 100% of the actions are forecast to be delivered.
FOI Exemptions Applied	None
Equality Screening Completed and Published	N/A
Recommendation/ Resolution	It is recommended that the Board should **APPROVE** the Corporate Performance Report.
Next steps	The next updated Corporate Performance Report for Quarter 3 will be presented to the Board on 19 January 2020.

The Regulation and Quality Improvement Authority

RQIA Corporate Performance Report

Quarter 2 - 2019-20

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Introduction

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

Traffic Light Rating System

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

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

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

action forecast to be completed by the completion date

action delivered

Summary of Traffic Light Rating System (Period Ending June 2019)

Traffic Light	June 2019	Actions that require exception reports
	0	
	0	
	21 (100%)	
	0	

Summary of Achievements

- An overview report on ‘Registered Nursing and Residential Homes and Bed Trends Report’ was published in June and shared with a range external stakeholders, to include DoH, Trusts and other ALBs.
- 1018 inspections have been completed to date which represents 42% of 2019-20 scheduled inspections
- 22 inspections were completed with lay assessor involvement

STRATEGIC THEME 1 Encourage quality improvement in health and social care services						
Action	**Measures**	**Delivery**				**Performance**
		Q1	**Q2**	**Q3**	**Q4**	
Action 1.1 We will lead an independent assurance process overseeing the sustainable implementation of the recommendations of the report of the Inquiry into Hyponatraemia-Related Deaths. **Forecast to be Delivered**	• Implementation of workstream nine arising from the O'Hara report.				x	The IHRD Workstream 9 continues to meet. The Assurance workstream has reviewed 90% of assurance frameworks and provided feedback. This work will continue over the next number of months until all of the workstreams and Sub-Groups have developed the content of the assurance framework for each of their recommendations including proposals on how implementation will be assessed.
Action 1.2 We will produce regular summaries of the quality of services we inspect, audit and review in 2019-20 **Forecast to be Delivered**	• Production of an overview report identifying common themes in non-regulated 16+ services • Quarterly summary of service reports of regulatory activity				x	An overview report on 'Registered Nursing and Residential Homes and Bed Trends Report' was published in June and shared with a range external stakeholders, to include DoH, Trusts and other ALBs. The report in respect to common themes in non-regulated 16+ services was finalised and shared with the DoH and HSCB during Quarter 2. In Q2 we also worked with Criminal Justice Inspectorate to finalise a report of the Safety of Prisoners Joint Inspection (publication date to be agreed); and completed a submission to the National Preventive Mechanism to inform part of the UK wide report on our activities which support the National Preventive Mechanism in upholding Human rights and prevention of torture

STRATEGIC THEME 1 Encourage quality improvement in health and social care services						
Action	**Measures**	**Delivery**				**Performance**
		Q1	**Q2**	**Q3**	**Q4**	
Action 1.3 We will implement the recommendations specific to RQIA from any external reports and reviews. **Forecast to be Delivered**	• Establish a central database for the collation, follow-up and reporting on recommendations relevant to RQIA from external reports and reviews • Implementation of recommendations arising from internal audit reports				x	A central database has been established within the Business Support Unit to collate, follow-up and report on recommendations. Oversight of the implementation of recommendations of Internal Audit reports has been designated to BSU and a regular overview will be presented to EMT and Audit Committee.
Action 1.4 We will provide systems to support improvement where we identify gaps in the quality of services we inspect **Forecast to be Delivered**	• Develop and implement an organisational wide Quality Improvement strategy • Develop and facilitate a programme of learning for RQIA staff involved in inspections				x	RQIA's Quality Improvement Strategy has been developed based on the capability assessment completed in 2018/19. The planning for a programme of learning and development has taken place with a view to commencing programme in quarter 3. A rolling programme of learning opportunities for staff will be developed based on our evolving approach to regulation and individual learning needs identified through appraisal. Three workshops to develop formulation skills have been arranged will be delivered by the end of quarter 2. RQIA's learning week has been arranged for quarter 3; a working group has been set up to finalise the training requirements. Places have been secured for RQIA staff to complete Level 2 advanced Quality Improvement Training through Safety Quality Belfast's (SQB) - Delivering Improvement programme which is starting in Q4; one member of staff has commenced Scottish Improvement Leader Training level 3.
Action 1.5 We will define outcome measures to demonstrate the impact of our work **Forecast to be Delivered**	• Establish a project group to take forward recommendation • Develop a suite of measures				x	The initiation of this project is planned for quarter 3. A suite of measures will be presented for consideration to EMT and the Board during Quarter 4.

STRATEGIC THEME 2 Use sources of information effectively						
Action	**Measures**	**Delivery**				**Performance**
		Q1	**Q2**	**Q3**	**Q4**	
Action 2.1 We will use enhanced intelligence to support our move to a risk-based model of regulation. **Forecast to be Delivered**	• Provider level self-service reporting • Service type benchmarking reports		x		x	Work to develop provider level reports is well underway and will be rolled out in quarter 2. Project Initiation Documents were developed in quarter 1 and approved by the Project Board on 22 May. Work to develop a RADaR approach to using existing information sources about children's services and a second project to review and expand information sources for receipt of intelligence about domiciliary care agencies and day care setting will commence in quarter 2. Provider level reports have been developed and rolled out across the organisation. We are currently developing alerts to identify when reporting of notifications falls outside normal parameters.
Action 2.2 We will examine how we can improve our use of qualitative and quantitative intelligence to support activity throughout the organisation **Forecast to be Delivered**	• Revise RQIA Management and Handling of Complaints policy and procedure • Develop a set of principles and framework for risk based decision making			x		A professional decision making workshop with David Carson (Barrister and writer of risk) was held during quarter one and work to develop principles has commenced through the inspection methodology workstream. This work will be completed by the Deputy Director of Assurance in quarter 3 and shared with staff. The Complaints policy will be reviewed and presented to EMT and the Board by December 2019.
Action 2.3 We will consider how we gather and disseminate examples of good practice in all the settings where we have a presence, in order that learning can be shared throughout the HSC system. **Forecast to be Delivered**	• Deliver 5 information workshops for providers of regulated services • Production of an e-newsletter for providers				x	Planning for four information workshops for providers of regulated services has commenced with ARC. The information workshops will be held during quarter 3, including sessions with providers of children's services.

STRATEGIC THEME 2 Use sources of information effectively						
Action	**Measures**	**Delivery**				**Performance**
		Q1	**Q2**	**Q3**	**Q4**	
Action 2.4 We will review our website to make better use of this resource in sharing information and intelligence in a meaningful way. **Forecast to be Delivered**	• Establish a working group to include participants from RQIA Membership Scheme and other stakeholders			x		We have met with our website provider to discuss introducing a pop up online user feedback survey, and conducting user experience to involve our Membership Scheme during Quarter 3.
Action 2.5 We will use our iConnect system to develop a framework to assess and monitor the effectiveness of our rights-based approach to inspection, review and audit activity **Forecast to be Delivered**					x	During quarter 2, a project team met to scope the framework to assess and monitor the effectiveness of our rights-based approach to inspection, review and audit activity. A human rights framework was integrated into the Care Homes Team. The implementation will be monitored during quarter 3. A project team was established in quarter 1 to cross reference human rights legislation with DoH Regulations and Nursing Standards in domiciliary care services initially. All staff completed a questionnaire regarding their awareness of human rights and the integration of the human rights framework into their inspection reports. The rollout of the human rights framework commenced in the care homes team in quarter 2. A further project team was established with a view to implementation of this framework in Q3. An easy read inspection report was developed and approved by the project team in quarter 2.

STRATEGIC THEME 3 Engage and involve service users and stakeholders						
Action	**Measures**	**Delivery**				**Performance**
		Q1	**Q2**	**Q3**	**Q4**	
Action 3.1 We will increase the profile of RQIA with the public. **Forecast to be Delivered**	• Refresh Membership Scheme to increase participation by 10% • Participate in the Household survey • Engagement Strategy				x	Planning has commenced to refresh RQIA's Membership Scheme participation through methods of social media and face to face engagement. We are currently considering the questions to be included in the Household survey. The Engagement Strategy was approved by the Board during quarter 2.
Action 3.2 We will work collaboratively to report on the lived experience of users of health and social care. **Forecast to be Delivered**	• Monthly liaison meetings with trusts • 5 meetings with young people currently living in children's homes across Ni • 1 meeting with care experienced young people and VOYPIC • 1 meeting with ARC 'TILII' Group				x	Two liaison meetings have been held with Trusts in June and meetings will be held with the other Trusts in quarter 2 and thereafter, monthly intelligence sharing meetings have been agreed with each Trust. We will work with VOYPIC to progress meetings between RQIA inspectors and care experienced young people to allow our inspectors to refine our inspection approach based on young people's experience. We will also engage with providers of Children's Homes to arrange meetings between RQIA inspectors and young people currently using Children's Homes across the region. A meeting with Assumpta Ryan Professor of Ageing and Health, School of Nursing and Institute of Nursing and Health Research held during quarter 2 to obtain a better understanding of the 'My Home Life' process. A meeting has been arranged for quarter 3 with ARC to explore potential of TILII (telling it like it is) group to deepen our understanding of lived experience for people with learning disabilities in regulated services.

STRATEGIC THEME 3 Engage and involve service users and stakeholders						
Action	**Measures**	**Delivery**				**Performance**
		Q1	**Q2**	**Q3**	**Q4**	
Action 3.3 We will set out in our revised inspection methodology how we will use lay assessors in all inspection activity **Forecast to be Delivered**	• Revised approach for involvement of service users, staff, family members and managers as part of our inspection methodology improvement work		x			This will be reported on as part of the inspection methodology programme to the Project Board was in quarter 2 and an update will be provided at the next meeting. Twenty two inspections to date have been completed with lay assessor involvement.
Action 3.4 We will facilitate one RQIA open house event where all stakeholders will be welcome to meet RQIA staff and learn about any aspect of our work. **Forecast to be Delivered**	• Facilitate one open house event			x		The Business Support Unit has planned and scheduled the open house event to take place on 10 October 2019.
Action 3.5 We will introduce a regular e-zine to communicate with our stakeholders. **Forecast to be Delivered**	• Development of a prototype newsletter to share with a reference group including RQIA Membership Scheme • Development of an internal newsletter to communicate with RQIA staff					Three editions of new in-house staff newsletter issued to all staff during quarters 1 and 2.

STRATEGIC THEME 3 Engage and involve service users and stakeholders						
Action	**Measures**	**Delivery**				**Performance**
		Q1	**Q2**	**Q3**	**Q4**	
Action 3.6 We will evaluate and revise our use of social media to ensure we are communicating in the most effective way for all our stakeholders. **Forecast to be Delivered**	• Establish a stakeholder reference group to review RQIA Social Media Channels • Review and revise RQIA Communications Strategy				x	We have commenced a review of our use of social media, and will establish a reference group in quarter 3. Engagement Strategy approved by Board during quarter 2.

STRATEGIC THEME 4 Deliver operational excellence						
Action	**Measures**	**Delivery**				**Performance**
		Q1	**Q2**	**Q3**	**Q4**	
Action 4.1 We will evaluate the implementation of the actions set out in our Transformation, Modernisation and Reform framework **Forecast to be Delivered**	• Evaluate the Transformation, Modernisation and Reform Framework • Prepare a business case for the introduction of an EDRMS to RQIA				x	Work has commenced with PaLS and BSO ITS to arrange for the development of an outline business case for an EDRMS system.
Action 4.2 We will develop and implement an organisational development plan to give our staff the skills they need to support transformation, modernisation and reform. **Forecast to be Delivered**	• Implementation of the recommendations and training programme from the review of the administration function in RQIA • 90% of staff will complete level one QI training during 2019/20 • 3% of staff will complete level two QI training during 2019/20 • 1% of staff will complete level three QI training during 2019/20 • 10 Quality Improvement Initiatives during 2019/20				x	A draft report of the review of the administration function in RQIA has been shared with the Head of Business Support. The findings and recommendations have been shared with the administrative staff during quarter 2. A number of recommendations have been implemented during quarter 2. All other recommendations will be implemented throughout Quarters 3 and 4. Staff training requirements will be built into appraisal of all staff to ensure targets can be met by quarter 4. 60% of RQIA staff have completed level 1 QI and we will target for completion of remaining 40% for Q3 and Q4. First cohort of level 2 training to commence in February 2020. Four Quality Improvement Initiatives commenced/completed (Learning Implemented from SAI's in Mental Health Unit; Strengthening Assurance of Controlled Drugs and Conscious Sedation in Dental Practice; Strengthening Assurance of Form 10 process; Introduction of Safety Briefs)

STRATEGIC THEME 4 Deliver operational excellence						
Action	**Measures**	**Delivery**				**Performance**
		Q1	**Q2**	**Q3**	**Q4**	
Action 4.3 We will analyse and evaluate the responses to the HSC Staff Survey in order to further revise our plans for internal transformation and reform. **Forecast to be Delivered**	• Development of an implementation plan arising from the HSC Staff Survey				x	Staff Survey results are expected during quarter 3.
Action 4.4 The review of our inspection methodology will include revised reporting formats **Forecast to be Delivered**	• Inspection reports for three types of services will be produced using more concise, easier to read, templates			x		Development of inspection report templates is underway and appointments for consultation on the report formats with external stakeholders have been arranged, results are expected quarter 3.
Action 4.5 We will examine and reform our registration processes to ensure they reflect a rights-based approach **Forecast to be Delivered**	• Application for variation, manager absence and voluntary cancellation to become electronic • Process for manager / responsible person and service application to become electronic	x			x	A Terms of Reference has been prepared and scoping work for this project is underway. Applications for variation, manager absence and voluntary cancellation have been available for submission through the web-portal since 1 April. In September, 100% of variations and 96% of manager absences were submitted via the web portal. Reference forms for manager / responsible person applications are requested and returned in electronic format. We are also now storing a number of documents electronically in iConnect rather than as paper copies and accepting digital Access NI certificates which will make the registration process much more efficient for applicants and for RQIA.

RQIA Board Meeting

Date of Meeting	21 November 2019
Title of Paper	Corporate Risk Assurance Framework Report
Agenda Item	5
Reference	H/09/19
Author	Jennifer Lamont
Presented by	Head of Business Support
Purpose	The purpose of this paper is to present the Corporate Risk Assurance Framework Report to the Board.
Executive Summary	The previous Corporate Risk Assurance Framework Report was presented to the Board on 4 July 2019/ A detailed Risk Log is attached at the start of the Corporate Risk Assurance Framework Report which details the changes that have been made to the risk register, as progressed by the Executive Management Team.
FOI Considerations	None
Equality Impact Assessment	Not applicable
Recommendation/ Resolution	The Board is asked to **APPROVE** the Corporate Risk Assurance Framework Report.
Next steps	None.

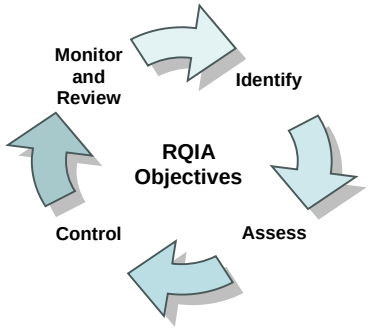
CORPORATE RISK ASSURANCE FRAMEWORK

Version Control:

Date of Review of Risk Register	Risk Coordinator
28/04/2019 Drafted for Audit Committee	Jennifer Lamont
2 May 2019 – Amended for RQIA Board on 16 July 2019	Jennifer Lamont
7 June 2019 – Reviewed for Audit Committee	Jennifer Lamont
11 October 2019 – Reviewed for Audit Committee	Jennifer Lamont

INTRODUCTION

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



IDENTIFY

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

ASSESS

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

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

CONTROL

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

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

MONITOR AND REVIEW

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

EXECUTIVE SUMMARY

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

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

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

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

RISK LOG				
LOW RISKS	**MEDIUM RISKS**	**HIGH RISKS**	**EXTREME RISKS**	**TOTAL NUMBER OF RISKS**
0	**4**	**2**	**0**	**6**

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

RISK SCORING MATRIX

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

Risk Log

Risk Reference	Description	Date Added
CR1	There is a risk that RQIA does not have the capacity (including financial resources, staff numbers, expertise, motivation, performance and capability) to deliver its organisational objectives and help the organisation improve.	**April 2019**
CR2	There is a risk that RQIA does not demonstrate and evidence its performance and impact – when working individually and in partnership with others - against its agreed objectives in alignment with the Programme for Government.	**April 2019**
CR3	There is a risk that the public, HSC professionals, providers, DoH and politicians lose confidence in RQIA as the independent NI HSC regulator if we do not take appropriate action when evidence suggests it is necessary and the rational for our actions is not sufficiently clear.	**April 2019**
CR4	There is a risk that intelligent monitoring of the data and information supplied to RQIA fails to pick up the expected level of provider failure; and that RQIA does not use this monitoring to appropriately influence actions and provide an effective remedial response.	**April 2019**
CR5	There is a risk that inspection and review activity fails to pick up significant provider risk and failure and that RQIA does not act appropriately on the findings of this activity.	**April 2019**
CR6	There is risk of a cyber-security incident which may result in RQIA's information, systems, and infrastructure becoming unreliable, not accessible (temporarily or permanently) or compromised by unauthorised 3rd parties potentially causing significant business disruption and reputational damage.	**September 2017**

Ref No.	Owner	Description	Current Controls	Assurances on Controls	Assessment			Actions and Additional Assurances	Action Owner	Target Date	Comments
Risk Id.	Title	What would prevent the objective being achieved or interrupt service delivery? Consider risks associated with people, processes, systems and information.	What controls / systems are in place already to manage the risk?	Where can we gain evidence that the controls we are relying on are in place and effective?	Likelihood	I Impact	Risk Rating	What additional actions can be implemented to further manage the risk and what measures can we apply to provide assurance that the additional controls will be effective?	Individual responsible for delivery.	Target date for action closure.	Comments as applicable.
CR1	Chief Executive	There is a risk that RQIA does not have the capacity (including financial resources, staff numbers, expertise, motivation, performance and capability) to deliver its organisational objectives and help the organisation improve.	• IIP accreditation; • Completion of appraisals and staff development plans; • Revised inspector recruitment procedures; • Active member of the Improvement Institute; • Membership of Q Community and Improvement Network NI; • Commencement of review of inspection methodology (regulated services); • Monthly monitoring meetings with BSO finance link person; • CP training delivered for all senior staff; • Quarterly meetings with DoH sponsor	• Staff vacancy, performance management and absence rates standing agenda item at weekly EMT; • EMT receive updates on local, regional and national improvement initiatives. • EMT and Board representation on project board of inspection review methodology; • Development of QI strategy; • Quarterly sponsorship meetings with DoH; • Monthly meetings between CEx & Head BSU and BSO finance	L	M	M	• IIP re-accreditation; • Implementation of QI strategy; • Recruitment of QI officers; • Evaluation of RQIA transformation to date; • Updates on HR, finance and improvement activity to EMT and Board.	Chief Executive Director of Improvement Director of Assurance Head of Business Support	March 2020	Reviewed quarterly

Ref No.	Owner	Description	Current Controls	Assurances on Controls	Assessment			Actions and Additional Assurances	Action Owner	Target Date	Comments
Risk Id.	Title	What would prevent the objective being achieved or interrupt service delivery? Consider risks associated with people, processes, systems and information.	What controls / systems are in place already to manage the risk?	Where can we gain evidence that the controls we are relying on are in place and effective?	Likelihood	I Impact	Risk Rating	What additional actions can be implemented to further manage the risk and what measures can we apply to provide assurance that the additional controls will be effective?	Individual responsible for delivery.	Target date for action closure.	Comments as applicable.
			branch; • Organisational restructure complete and new staff management arrangements in place.	business partner to oversee planned and actual spend; • Monthly meetings Head BSU and BSO HR business partner to oversee emerging HR issues.							

Ref No.	Owner	Description	Current Controls	Assurances on Controls	Assessment			Actions and Additional Assurances	Action Owner	Target Date	Comments
Risk Id.	Title	What would prevent the objective being achieved or interrupt service delivery? Consider risks associated with people, processes, systems and information.	What controls / systems are in place already to manage the risk?	Where can we gain evidence that the controls we are relying on are in place and effective?	Likelihood	I Impact	Risk Rating	What additional actions can be implemented to further manage the risk and what measures can we apply to provide assurance that the additional controls will be effective?	Individual responsible for delivery.	Target date for action closure.	Comments as applicable.
CR2	Chief Executive	There is a risk that RQIA does not demonstrate and evidence its performance and impact – when working individually and in partnership with others - against its agreed objectives in alignment with the Programme for Government.	• RQIA Business Plan and accompanying deliverables as described in directorate plans; • Corporate performance reporting; • Review of inspection methodology; • Comms and engagement strategy; • RQIA membership scheme.	• Links with critical friends in CQC & HIS; • MOUs with external stakeholders;	L	M	M	• RQIA reports included in review of inspection methodology; • Revised comms and engagement strategy.	Chief Executive Director of Improvement Director of Assurance	March 2020	Reviewed quarterly

Ref No.	Owner	Description	Current Controls	Assurances on Controls	Assessment			Actions and Additional Assurances	Action Owner	Target Date	Comments
Risk Id.	Title	What would prevent the objective being achieved or interrupt service delivery? Consider risks associated with people, processes, systems and information.	What controls / systems are in place already to manage the risk?	Where can we gain evidence that the controls we are relying on are in place and effective?	Likelihood	I Impact	Risk Rating	What additional actions can be implemented to further manage the risk and what measures can we apply to provide assurance that the additional controls will be effective?	Individual responsible for delivery.	Target date for action closure.	Comments as applicable.
CR3	Chief Executive	There is a risk that the public, HSC professionals, providers, DoH and politicians lose confidence in RQIA as the independent NI HSC regulator if we do not take appropriate action when evidence suggests it is necessary and the rational for our actions is not sufficiently clear.	• Comms and engagement strategy; • Membership scheme launched;		M	H	H	• Review of RQIA website; • Review of comms and engagement strategy; • Publication of stats and information bulletin for RQIA; • Principles of co-production embedded in all our work	Chief Executive Head of Business Support	March 2020	Reviewed quarterly

Ref No.	Owner	Description	Current Controls	Assurances on Controls	Assessment			Actions and Additional Assurances	Action Owner	Target Date	Comments
Risk Id.	Title	What would prevent the objective being achieved or interrupt service delivery? Consider risks associated with people, processes, systems and information.	What controls / systems are in place already to manage the risk?	Where can we gain evidence that the controls we are relying on are in place and effective?	Likelihood	I Impact	Risk Rating	What additional actions can be implemented to further manage the risk and what measures can we apply to provide assurance that the additional controls will be effective?	Individual responsible for delivery.	Target date for action closure.	Comments as applicable.
CR4	Chief Executive	There is a risk that intelligent monitoring of the data and information supplied to RQIA fails to pick up the expected level of provider failure; and that RQIA does not use this monitoring to appropriately influence actions and provide an effective remedial response.	• Introduction of <name> reports; • Revision of concerns model on iConnect; • Implementation of RADAR.	• Introduction of safety huddles; • Assessment and evaluation of RADAR.	M	M	M	• Information team capacity increased with additional staffing; • Enhanced links with external data sources; • Roll out of safety huddle model across RQIA teams; • Extension of RADAR	Chief Executive Director of Improvement Director of Assurance Head of Business Support	March 2020	Reviewed quarterly

Ref No.	Owner	Description	Current Controls	Assurances on Controls	Assessment			Actions and Additional Assurances	Action Owner	Target Date	Comments
Risk Id.	Title	What would prevent the objective being achieved or interrupt service delivery? Consider risks associated with people, processes, systems and information.	What controls / systems are in place already to manage the risk?	Where can we gain evidence that the controls we are relying on are in place and effective?	Likelihood	I Impact	Risk Rating	What additional actions can be implemented to further manage the risk and what measures can we apply to provide assurance that the additional controls will be effective?	Individual responsible for delivery.	Target date for action closure.	Comments as applicable.
CR5	Chief Executive	There is a risk that inspection and review activity fails to pick up significant provider risk and failure and that RQIA does not act appropriately on the findings of this activity.	• Enforcement decision making policy and procedures; • Dedicated in-house solicitor for Neurology review work; • SCCG; • Duty desk; • Complaints guidance leaflet introduced.	• SCCG TOR and procedures revised and implemented; • iConnect concerns module revised to support duty desk.	M	M	M	• Review of inspection methodology to include enforcement decision making.	Chief Executive Director of Improvement Director of Assurance	March 2020	Reviewed quarterly

Ref No.	Owner	Description	Current Controls	Assurances on Controls	Assessment			Actions and Additional Assurances	Action Owner	Target Date	Comments
Risk Id.	Title	What would prevent the objective being achieved or interrupt service delivery? Consider risks associated with people, processes, systems and information.	What controls / systems are in place already to manage the risk?	Where can we gain evidence that the controls we are relying on are in place and effective?	Likelihood	I Impact	Risk Rating	What additional actions can be implemented to further manage the risk and what measures can we apply to provide assurance that the additional controls will be effective?	Individual responsible for delivery.	Target date for action closure.	Comments as applicable.
CR6	Chief Executive	There is risk of a cybersecurity incident which may result in RQIA's information, systems, and infrastructure becoming unreliable, not accessible (temporarily or permanently) or compromised by unauthorised 3rd parties potentially causing significant business disruption and reputational damage.	• Technical infrastructure including security hardware (firewalls), security software, server/client patching, data and system back-ups, 3rd party remote secure access; • Policy and process controls; • User behaviours	• Self-assessment /substantive compliance against the Information Management Assurance Checklist; • SLA with BSO ITS to provide ICT service provision and security.	L	H	H		Chief Executive Head of Business Support	March 2020	Reviewed quarterly

RQIA Board Meeting

Date of Meeting	21 November 2019
Title of Paper	Records Management Policy
Agenda Item	6
Reference	i/09/19
Author	Hayley Barrett
Presented by	Head of Business Support
Purpose	The purpose of this paper is to share the updated Records Management Policy for approval.
Executive Summary	All Health and Social Care (HSC) records are public records under the terms of the Public Records Act (NI) 1923. The Act sets out the broad responsibilities for everyone who works with such records and, as such, RQIA has a statutory duty to make arrangements for the management and safekeeping of its records, and for their retention, storage and eventual disposal. The policy will be supported by a RQIA retention and disposal schedule.
FOI Considerations	None
Equality Impact Assessment	Not applicable
Recommendation/ Resolution	The Board is asked to **APPROVE** the Records Management Policy.
Next steps	Circulate to all staff.

Records Management Policy

Policy Type	Business Support
Directorate Area	All Directorates
Policy author / champion	Business Manager / Head of Business Support
Equality Screened	N/A
Date approved by Executive Team	23 September 2019
Date approved by Audit Committee	17 October 2019
Date approved by Board	
Date of issue to RQIA staff	
Date of Review	

1. Introduction

All Health and Social Care (HSC) records are public records under the terms of the Public Records Act (NI) 1923. The Act sets out the broad responsibilities for everyone who works with such records and, as such, RQIA has a statutory duty to make arrangements for the management and safekeeping of its records, and for their retention, storage and eventual disposal.

A record can be described as "information created, received and maintained as evidence and information by an organisation or person, in pursuance of legal obligations or in the traction of business" (International Standard of Managing Record ISO15489). This policy covers all records in all formats: electronic, paper, digital and/or voice; created, collated, processed, used, stored and/or disposed of in the course of RQIA's business.

In the context of Good Management Good Records[1] a record is anything which contains information (in any media) which has been created or gathered as a result of any aspect of the work of employees or those providing a service– including consultants, General Practitioners, Dentists , Opticians, Pharmacists, agency, or casual staff and all contracted services.

DoH, HSC and Public Safety records are public records as defined in the Public Records Act (NI) 1923.

Records management is:

- the systematic and consistent control of all records, regardless of the media on which they are held, throughout their lifecycle - it includes setting up the infrastructure or system into which the records are created, received or added as well as the process of record creation itself;
- organising the records so that related records are grouped together, usually according to a file plan or classification scheme (managing groups of related records is more efficient than managing many individual records); and
- the retention and disposal actions such as destruction or transfer to Public Records Office of Northern Ireland (PRONI) at the appropriate time and procedures for documenting those actions.

RQIA must know what records it has in order to manage them. Control of the records depends on a range of carefully developed procedures applied to them before their creation through to their disposal.

There are five vital elements of records management:

- meeting business and patient/client needs
- public records legislation
- managing records as a valuable and expensive asset
- accountability for practice and service provision
- accountability and quality of information and services

[1] https://www.health-ni.gov.uk/articles/gmgr-records-management

2. Scope

RQIA recognises that the efficient management of its records is necessary to support its core functions and to comply with its legal and regulatory obligations. This policy applies to all RQIA staff and should be read in conjunction with the following:

- RQIA policies and procedures on Information Governance
- RQIA policies and procedures on ICT
- Public Records Act (NI) 1923
- Disposal of Documents Order No 167, 1925
- Limitation Act 1980
- Freedom of Information Act 2000
- International Standard of Records Management (ISO 15489)
- Electronic Records Management: Toolkits (PRO, 2000)
- Data Protection Act 2018: A Guide for Records Managers and Archivists (PRO, PRONI, NAS, in association with ODPC, 2000)
- Records Management Standards and Guidance (PRO, from 1998)
- Northern Ireland Records Management Standards (NIRMS) (2002) (Public Records Office of Northern Ireland)
- The Lord Chancellor's Code of Practice on the Management of Records under Section 46 of the Freedom of Information
- Good Management, Good Records, Guidelines for Managing Records in Health and personal Social Services Organisations in Northern Ireland, DHSSPSNI
- Human Rights Act 1998
- Office of the Ombudsman – The importance of good record keeping

Records should meet RQIA's legal and operational requirements and support accountability in decisions taken by its officers and Board. It is therefore vital that management of information is treated as an administrative discipline which controls all aspects of the record from creation through to disposal in an appropriate manner.

3. The Policy Statement

Information is a corporate asset and RQIA's records are vital in both its current and future work, for the purposes of accountability and for an awareness and understanding of its history.

In consultation with organisations that may be concerned with the management of its records, RQIA will create, use, manage and destroy or retain / preserve its records in accordance with statutory requirements.

Systematic records management is fundamental to organisational efficiency. It ensures that the correct information is:

- captured, stored, retrieved and destroyed or retained/preserved according to need;
- fully utilised to meet current and future needs and to support change; and
- accessible to those who need to make use of it.

All RQIA staff who create, use, manage or dispose of records have a duty to protect them and ensure that any information they add to the record is necessary, accurate and complete. The confidentiality of client and staff records must always be of primary concern to RQIA staff.

Records Management is a specific part of RQIA's Information Governance Strategy and the Information Governance Group[2] is responsible for maintaining the accuracy and relevance of this policy and providing assurance to RQIA's Executive Team and Board as to its implementation and effectiveness.

4. Aims and Objectives of Records Management

The aim of this policy is to ensure the quality of RQIA's records; to maintain, retain or dispose of these records in accordance with RQIA's need and legislative requirements and to ensure the permanent preservation of appropriately identified records. The detailed objectives are to:

- ensure that the record is present, accurate and complete
- maintain effective records control systems
- improve information retrieval methods by maintaining effective filing systems
- ensure the record provides a reliable and accountable representation of business activity and, if relevant, provides the rationale behind the decision-making process
- maintain procedures for retention and disposal of records

5. Responsibilities

Records management is recognised as a specific corporate responsibility within RQIA and there is a managerial focus for records of all types in all formats, including electronic records, throughout their life cycle, from planning and creation through to disposal.

The **RQIA Board** will oversee the effective record management by officers of RQIA.

The **Chief Executive** and **Directors** have a duty to ensure that the RQIA complies with the requirements of legislation affecting management of the records and with supporting regulations and codes.

The **Head of Business Support** and members of the **Information Governance Group** will work closely with all staff to ensure that there is consistency in the management of records and that advice and guidance on good records management practice is provided throughout the organisation. The Head of Business Support will co-ordinate the Information Governance Group and the need to establish a coordinating group specific to Records Management will be kept under review.

[2] Information Governance Group includes RQIA SIRO and relevant staff across the organisation responsible for maintaining the accuracy and relevance of this policy (i.e Business Manager and Business Support Officers)

Senior Managers and **Line Managers** will ensure that records are managed effectively in each service area in accordance with this policy. They are responsible for ensuring staff members are aware of their responsibilities under this policy and local records management procedures. Specifically they will be responsible for ensuring that:

- any policies, procedures or protocols agreed by RQIA are implemented within their area;
- appropriate employees are designated to assist with the implementation of records management procedures within their area;
- employees are supported in terms of training and development in their adherence to the Records Management Policy and procedures;
- individual patient information, were applicable, is not kept longer than is necessary. Information about individual patients may not be passed on to others without the individual's consent except as permitted under Schedule 2 and 3 of the Data Protection Act 2018 and relevant data sharing protocols issued by DoH;
- staff know what to record, how to record and why to record;
- an inventory of records is maintained which shows the nature and type of records within service function, activity and directorate, is accessible to users and indicates the specific retention periods for those records; and
- staff who record, handle, store or otherwise come into contact with patient information are aware that they have a common law duty of confidence to patients. Such a duty will continue even after the death of a patient.

All members of staff, whether permanent, temporary or contracted, are responsible for documenting their actions and decisions in the records and for maintaining records in accordance with good practice and professional guidelines. All staff are responsible for:

- ensuring they have a clear understanding of records management and demonstrate commitment to duties relating to record keeping;
- creating records which are consistent, reliable, accurate and complete;
- capturing records which authentically document activities in the course of which they were produced;
- filing records correctly in the appropriate area of RQIA's filing system on the server;
- applying security and access controls to records where appropriate; and
- identifying and applying appropriate disposal and retention periods to records.

"Good Management, Good Records" is available to all staff on the intranet and by internet access to the DoH website.

"A guide to Good Record Keeping" is available to all staff on the intranet.

RQIA will seek advice from BSO Information Governance Manager as and when required.

6. Record Filing Structure

RQIA's records are stored electronically on a central server and in paper based format. A process to cease creating paper based / manual folders in which to store records has commenced. Manual and electronic folders are retained and will be managed and disposed of as per RQIA's Retention and Disposal Schedule.

The Head of Business Support will monitor the storage and retention of RQIA's records and, through the Information Governance Group, will ensure RQIA's Operational Procedure for its filing system and guidance within Good Management, Good Records is being followed by all staff.

Should RQIA decide to introduce an Electronic Document and Records Management System (EDRMS) the system will be designed to meet the requirement of the British Standard BS 10008 to ensure authenticity of records during legal proceedings and the records registration process will be reviewed and revised for consistency.

7. Retention and Disposal of Records

All records should be retained and disposed of in accordance with RQIA's Retention and Disposal Schedule, adapted from the Department of Health's Good Management, Good Records (GMGR).

A regular quality check of RQIA's filing system will be undertaken by the nominated staff within the Business Support Unit. In liaison with RQIA's Executive Team and approval of the Chief Executive, relevant manual and electronic files will be archived, disposed of, and, where relevant, forwarded to PRONI for permanent preservation.

8. Monitoring Compliance

Monitoring of compliance with this policy will be undertaken by RQIA's Information Governance Group, reporting any issues to RQIA's Executive Team in order to agree any changes required or action to be taken.

An assessment of compliance with requirements within the Information Management Assurance Checklist will be undertaken each year. Annual reports and proposed action/development plans will be presented to the Executive Team, RQIA Audit and Risk Committee and Board for approval.

9. Equality

This policy has been screened for equality implications are required by Section 75 and Schedule 9 of the Northern Ireland Action 1998. No significant equality or human rights implications have been identified. The policy will therefore not be subject to equality impact assessment.

RQIA Board Meeting

Date of Meeting	21 November 2019
Title of Paper	RQIA Finance Update
Agenda Item	7
Reference	J/09/19
Author	Head of Business Support Unit
Presented by	Head of Business Support Unit
Purpose	To provide the RQIA with an update in relation to RQIA Finances at Month 5.
Executive Summary	RQIA are forecast to breakeven at year end.
FOI Exemptions Applied	None
Equality Screening Completed and Published	N/A
Recommendation/ Resolution	It is recommended that the Board should **NOTE** the RQIA Finance Update.
Next steps	None

RQIA FINANCE UPDATE

1. This paper sets out key issues for the Board to note in respect of RQIA Finances at the end of Month 5.

2. We continue to be supported by our BSO Business Partner in our financial governance. Monthly meetings take place with the Head of Business Support and Chief Executive where all issues are discussed in depth. This update is based on the position at the end of month five (31 August 2019).

3. We are currently operating with a pay underspend of £36k. This is due to staff absence on sickness (at half or no pay) and unfilled vacancies. We are working with BSO HR to bring relevant staff back to work and to recruit to our vacant posts.

4. Our non-pay expenditure is running at a £50k underspend. This is mainly due to the spend on the review programme not being incurred on a regular monthly basis. The review programme budget is generally spent towards the end of the year and we are confident that we will not incur a significant underspend at year end.

5. We have factored for a 1% pay rise in this year's budget build. We have recently been asked to assess the impact of a potential 3% pay rise. A 3% pay award would result in an additional £118.7k cost to RQIA – however, based on last year's experience, this will be added to our RRL by DoH if necessary.

6. We did not declare and surplus or pressures in the most recent monitoring round. Given the time necessary to fill vacant positions, we may declare a small surplus in the next round.

Jennifer Lamont
Head of Business Support

The Regulation and Quality Improvement Authority

RQIA Board Meeting

Date of Meeting	21 November 2019
Title of Paper	Chief Executive's Update
Agenda Item	9
Reference	K/09/19
Author	Chief Executive
Presented by	Chief Executive
Purpose	The purpose of the paper is to update the Board on strategic issues which the Chief Executive and EMT has been dealing with since the Board meeting on 26 September and to advise Board members of other key developments or issues.
Executive Summary	This paper provides an update to the Board of the key developments for RQIA since the last Board meeting.
FOI Exemptions Applied	None
Equality Impact Assessment	Not applicable
Recommendation/ Resolution	It is recommended that the Board should **NOTE** the Chief Executive's Update.
Next steps	A further update will be provided at the November meeting.

BUSINESS SUPPORT UNIT

Media Interest

Since the last Board meeting there has been significant print, broadcast and online media interest in a range of RQIA's activities.

Enforcement actions at Owen Mor Care Centre and Brooklands nursing homes in Derry and Strabane and District Caring Services domiciliary care agency received considerable coverage, with BBC Radio Foyle taking a particular interest in ongoing developments at these services. There was also interest from a range of outlets in our role in relation to mental health services across Northern Ireland as well as BBC coverage on the potential impact of Brexit on HSC services.

Engagement

On 10 October RQIA held its first Open House, where members of the public had an opportunity to visit our offices to meet our staff; hear about our work to assure public confidence in health and social care; speak directly to our senior management team and acting Chair and ask them about any aspect of our work; and find out how they can get involved in our work. The event was promoted through social media channels, newspapers and with support from partner organisations including Age Sector Platform, Age NI, VOYPIC, the Patient and Client Council, HSC Board, Ulster University and QUB. Feedback from attendees was highly positive and we will use this to inform future public engagement activities

Political Engagement

The Ulster Unionist Party health spokesperson attended our Open House event, and we also responded to requests for briefings on various aspects of our work to a number of politicians. During the current election period RQIA will comply with relevant guidance relating to public communication and engagement.

Complaints

Since the last Board meeting we have received three complaints about RQIA. One was addressed at local resolution stage; another dating back several years falls outside timescales for investigation; and the third is being managed in line with our complaints policy and procedures.

Chief Executive Key Meetings

- 2 September - Chief Executive Forum
- 10 September - DoLs Regional meeting
- 18 September - HSCQI Leadership Alliance
- 23 September - MCA Meeting Deputy Director Social Work Children's
- 24 September - IHRD Service user and Carers Liaison Group
- 25 September - Cypriot Ministry of Health Visit to RQIA
- 25 September - Regulator Meeting with Four Seasons Health Care
- 30 September - Public Health Approach to Palliative Care
- 30 September - Invitation to engage with service users and families on SAI incident process
- 1 October - Muckamore Departmental Assurance Group
- 1 October - Expert review of Decrease Patients - neurology review
- 1 October - Dunmurry Manor Reference group meeting
- 1 October - IHRD Implementation Programme Management Group Meeting
- 4 October - NIPEC Regional workshop of professionals
- 8 October - Permanent Secretary Neurology Recall Assurance Group
- 8 October - Meeting with COPNI
- 17 October - IHCP Award Ceremony
- 21 October - Hyponatraemia Implementation Programme
- 21 October - CPEA RADaR Presentation
- 22 October - Regulator Meeting with Four Seasons Health Care
- 22October - ENRICH Launch - Age NI/PHA
- 23 October - Make Change Together Patient and Client Council
- 24 October - General Dental Council Chair Visit to NI - RQIA

Legal Action
We have received two 'statements of claim' for the next stage of proceedings in relation to McVicker and Bell (deceased) v Runwood Homes and RQIA.

Memorandum of Understand (MoU)
The MoU between BSO and HSC Clients in respect of the Data Controller and Data Processing has been approved and is available on RQIA Website. The MoU was issued under Article 28 (3) of the General Data Protection Regulation (GDPR) and will support the Service Level Agreements (SLAs) between BSO and the HSC Clients.

Finance
A finance paper is presented under separate cover.

Current Enforcement Action

Name of Service	Type of enforcement	Date of Issue	Compliance required by
NI Ambulance Service Headquarters (NIAS, Mr M Bloomfield)	1 x IN	21 December 2018	31 March 2020
Owen Mor Care Centre Nursing Home, Derry	4 x FTC 5 x COR	15 May 2019 16 August 2019	Ongoing
Western HSC Trust, Directorate of Adult Mental Health and Disability Services (Beech, Lime and Elm wards (Tyrone and Fermanagh Hospital, Omagh) and Carrick and Evish wards (Grangewood Hospital, L'Derry) (Dr A Kilgallen)	1 x IN	22 July 2019	22 October 2019
Valley Nursing Home, Clogher (Valley Nursing Home (MPA) Ltd)	1 x NOP 1x NOD	24 July 2019 18 September 2019	Ongoing
Brooklands Healthcare Londonderry (Nursing Home) (Brooklands Healthcare Ltd)	2 x FTC	12 August 2019	12 November 2019
Muckamore Abbey Hospital (Belfast HSC Trust)(Mr M Dillon)	3 x IN	16 August 2019	16 November 2019
Fortview, Residential Care Home, Dromore, Co Tyrone (Mr P Tolan)	1 x NOP	18 October 2019	Ongoing
Pine Lodge, Belmont Road, Belfast (BHSCT)	1 x NOP	29 October 2019	Ongoing

ASSURANCE DIRECTORATE

Care Homes Team

RADaR (Risk Adjusted Dynamic and Responsive)

The RADaR project team met on 27 September to progress the issues from the May Workshop such as the development of a risk matrix for pharmacy / estates / finance and the roll out of the tool across the other service areas. Statistical analysis is ongoing in relation to the findings from the scaled inspection tool and the differences between residential and nursing homes assessed level of risk which will be used to inform an academic summary paper written in collaboration with Prof Brian Taylor from the University of Ulster.

Four Seasons Health Care

I remain in regular contact with Four Seasons Health Care (FSHC), HSCB, DoH and Trusts in relation to the sale of the health care group. I have received confirmation from FSHC that the sale has not closed and the group is on the market again.

Meeting with COPNI

The acting Chair, Director and Deputy Director of Assurance and Head of Business Support and I met with COPNI on 8 October to discuss concerns in relation to Owen Mor.

The Head of Business Support subsequently met with COPNI representatives to re-establish regular liaison meetings. The meeting was positive.

Meeting with Families of Service Users of Owen Mor

In October, we issued a letter to relatives and carers of current Owen Mor patients inviting them to contact the Director of Assurance regarding any concerns, or positive comments, about the care provided by the Home.

I along with the Director of Assurance and the Responsible Individual for Owen Mor attended a meeting convened by Western HSC Trust to discuss actions taken to date and to identify proposed variations that will be submitted by the provider regarding their registration.

Day Care, Agencies, Estates, Finance & Pharmacy

The registration of satellite units associated with registered day centres has now been completed. All satellite units have now registered as standalone day centres or have deregistered.

Two road shows with nursing and residential care home providers were held in Omagh and Belfast in October. The road shows focussed on our human rights approach to inspection and highlighted challenges identified. The team also gave a short presentation on Deprivation of Liberty and what we will be focussing on during inspection once the Mental Capacity Act is partially implement in December.

Enforcement Action

Valley Nursing Home

We inspected the Valley Nursing Home on 31 October following receipt of information from a whistleblower.

The failings were seen in the context of poor regulatory history and on 4 November the team met with provider representatives. The provider made substantial commitments to increase management staffing and stronger governance oversight, leading to full compliance within 3 months. Within a greatly increased monitoring regime, this led to a decision to not issue a Notice of Proposal.

Gosna

Following information received from NISCC regarding potential illegal work practices in Gosna Care Agency, we met with the SEHSCT and were informed of a number of incidents being managed under the Trust's performance review process.

As a result of an unannounced inspection, on 21 October, and further to a Decision Making Panel, we applied to a lay magistrate for an urgent order to cancel the RI's registration. The order was served on 24 October. We worked closely with the SEHSCT and NISCC to keep them informed of our process. An early alert in relation to this enforcement work was sent to the Department.

Effective from 14 October, enforcement in relation to the management of incidents and missed calls placed on Strabane and District Caring Services Domiciliary Care Agency has been lifted.

Children's Services

Unregistered Facilities Accommodating Young People

The 16+ Supported Accommodation Report was sent to DoH and HSCB on 11 October. The Children's Team will continue to inspect these services against the Standards. A review of Supported Lodgings will be completed by 31 March 2020.

Monthly Monitoring Reports

A workshop on monthly monitoring occurred on 19 September. The aim was to improve the effectiveness of monitoring and the quality of information reported to RQIA. We will continue to support Trust managers in this practice area.

A further three regional workshops were delivered to support providers in service improvement, with particular focus on governance; a theme emerging from recent inspections.

Engagement with young people

Engagement sessions with VOYPIC and young people living in Trust children's homes, are planned to start in January 2020. Any significant findings will be integrated into our inspection approach next year.

Admission of Young People to Adult Wards

There has been a decrease in the number of under 18 admissions to adult wards; 8 admissions in Quarter 1 down to 3 in Quarter 2. The decrease is interesting given that one of the two wards in the regional CAMHS inpatient facility at Beechcroft was temporarily closed throughout Quarter 2.

IMPROVEMENT DIRECTORATE

Northern Ireland Ambulance Service (NIAS)

We held a Serious Concerns meeting with senior representatives from NIAS on 11 September in relation to their progress towards compliance with the Improvement Notice issued on 21 December 2018. We considered the findings from our unannounced inspection on 29 and 30 July and the information provided to us during this meeting.

We noted that work has progressed on an organisation-wide Infection Prevention and Control Training Strategy. At the time of our inspection we could not evidence organisation wide implementation of the training or robust assurance systems to support the implementation. We recognised the commitment shown by NIAS to deliver the required improvements and have determined to extend the date for compliance until 31 March 2020. We will meet with NIAS in February 2020 to enable them to update us with their progress towards compliance with the Improvement Notice.

Mental Health and Learning Disability

South Eastern Health and Social Care Trust

We have had ongoing engagement with South Eastern HSC Trust with respect to their plans to address concerns related to the mixed model of care (PICU and low secure) provided on Ward 27, Downshire Hospital. At a meeting with the Trust on 25 October we were provided with a copy of plans to create a separate ward for patients requiring a PICU environment. Building works will commence in the near future with an expected completion date of October 2020. We are content that the interim arrangements to mitigate risks (namely additional consultant cover) are satisfactory. We will continue to engage with the Trust to monitor progress in relation this model of care.

Belfast Health and Social Care Trust

We met with the Belfast HSC Trust representatives on 2 October to discuss progress towards compliance with the actions outlined in their Improvement Notices in relation to Muckamore Abbey Hospital. We have planned further progress meetings. The date for compliance with these Improvement Notices is 16 November.

We continue to meet regularly with the PSNI and Belfast HSC Trust under Adult Safeguarding Joint Protocol arrangements in relation to historic adult safeguarding concerns. Dr Geoghegan attends the Muckamore Departmental Assurance Group (MDAG) meetings.

Western Health and Social Care Trust

The Trust submitted their action plan by way of progress towards compliance with the actions outlined in their Improvement Notice issued in respect of Carrick and Evish Wards. The date for compliance with the Improvement Notice was 22 October.

Audit Mental Health (Northern Ireland) Order 1986 Form 10

As part of ongoing improvement work in respect of receipt and oversight of Form 10s, received under the Mental Health Order 1986, we are currently engaging with the relevant personnel in the DoH and the HSC Trusts.

National Preventive Mechanism (NPM)
We have completed a submission to the NPM to inform the next UK-wide Annual NPM Report on our activities which support the NPM for upholding Human Rights and Prevention of Torture.

Independent Healthcare

International Atomic Energy Agency (IAEA)
Board members are aware that the International Atomic Energy Agency (IAEA) carried out an Integrated Regulatory Review Service Mission in the UK from 14 – 25 October. We attended the mission, submitted a detailed self-assessment and supporting evidence to the IAEA inspectors. We were interviewed by IAEA inspectors in relation to the delivery of our IR(ME)R programme in Northern Ireland and we received no recommendations in the final report.

Remote Prescribing High Level Principles for all Healthcare Professions
On 8 November along with a number of other healthcare regulators and organisations we published High Level Principles for Good Practice in Remote Consultations and Prescribing. The principles outline a clear set of expectations for all UK healthcare professionals when prescribing remotely, whether online, over video-link or by phone.

Remote consultations and prescribing can benefit patients who want flexible access to healthcare. However, there are potential patient safety risks, particularly when the remote healthcare provider is not their regular prescriber. This work is part of our shared commitment to encourage good practice and ensure suitable safeguards are in place to protect patients. The high level principles are underpinned by existing standards and guidance from professional and system regulators. They include that health care professionals are expected to:

- Understand how to identify vulnerable patients and take appropriate steps to protect them;
- Carry out clinical assessments and medical record checks to make sure medication is safe and appropriate;
- Raise concerns when adequate patient safeguards aren't in place.

Reviews

We published two review reports in September: A Review of the Implementation of the Developing Eyecare Partnerships Strategy and A Review of Emergency Mental Health Service Provision across Northern Ireland.

Review of Governance of Outpatients Services in the Belfast HSC Trust with a Focus on Neurology and Other High Volume Specialties
We are finalising this review report, with a view to publishing shortly.

Expert Review of Clinical Case Notes of Patients of Dr X who have Died in the Previous 10 Years
Board members are aware that we continue to progress preparatory work, with meetings with our stakeholder organisations. We are finalising our Legal Framework in respect of accessing data and receiving patient records, along with operational protocols and preparations in relation to identifying the cohort of deceased patients.

Review of Governance Arrangements in Independent (Private) Hospitals and Hospices in Northern Ireland
We held workshops in October to focus our analyses and outputs from fieldwork. We have commenced drafting this review report.

Review of Serious Adverse Incidents (SAIs)
This review is currently in fieldwork and we will meet with staff from across HSC Trusts, HSC Board and PHA during November and December. We are finalising arrangements for engagement with patients / families.

Review of Vulnerable Prisoners
Preparatory work to support this review is underway. The review will include all prisons and we aim to complete within one year of commencement.

Review of Paediatric General Surgery
To be published following the General Election.

Audit, Guidelines and Quality Improvement (QI) Prototypes

2018-2019 Programme
We published two reports on 8 November - Electronic Methods to Improve Quality of Physical Health Monitoring in Patients with Mental Health Conditions; and The Audit of NICE Clinical Guideline 139.

We published the Guideline "Planning to Birth at Home in Northern Ireland" on 14 November to coincide with a planned event hosted by the Chief Nursing Officer.

2019-2020 Programme
We continue to support the four audit projects: Re-audit of Medicines Reconciliation of the Immediate Discharge Document, Red Flag referrals to BHSCT Dentistry, Stroke Network Regional TIA re-audit, Audit of Guideline for Admissions to MLU Units; and two quality improvement prototypes: Development of Patient Information Leaflets and Departmental Cancer Handbook, Self-sampling to Decrease the DNA Rate in People Referred to Colposcopy or on Follow up for Cervical Abnormalities.

2020-2021 Programme
We have closed the funding application process for 2020-2021 Programme.

RQIA Board Meeting

Date of Meeting	21 November 2019
Title of Paper	Audit and Risk Committee Business
Agenda Item	10
Reference	K/09/19
Author	Hayley Barrett
Presented by	Denis Power
Purpose	The purpose of this paper is to update the RQIA Board on the recent Audit Committee meetings.
Executive Summary	The Audit and Risk Committee has met on one occasion since the last Board meeting. At the meeting on 17 October 2019, the minutes of the meeting of 14 June 2019 were approved and these are attached for noting by the Board. The Committee Chairman will verbally update the Board on the meeting of 17 October 2019.
FOI Considerations	None
Equality Impact Assessment	Not applicable
Recommendation/ Resolution	The Board is asked to **NOTE** the update from the Committee Chair.
Next steps	The Audit and Risk Committee is scheduled to meet again on 5 March 2020.

MINUTES

RQIA Audit and Risk Committee Meeting 14 June 2019
Boardroom, 9th Floor, Riverside Tower, Belfast, 10:00am

Present	**In attendance**
Denis Power (Chair)	Jennifer Lamont (Head of Business Support)
Patricia O'Callaghan *(POC)*	Catherine McKeown (Head of Internal Audit)
Gerry McCurdy *(GMcC)*	Rosemary Peters Gallagher (Moore Stephens (NI) LLP)
Seamus Magee (*SM)*	Denver Lynn (Northern Ireland Audit Office)
	Ciara Flanagan (BSO Senior Client Accountant)
	Hayley Barrett (Board & Executive Support Manager)

Apologies
Olive Macleod (Chief Executive)
David Charles (Assistant Head of Internal Audit)
Stephen Knox (Northern Ireland Audit Office)
Robin Mullan
Lindsey Smith

1.0 Welcome and Apologies

1.1 The Chair welcomed all members and officers to the Audit Committee meeting. Apologies were noted from Robin Mullan, Lindsey Smith, David Charles, Internal Audit and Stephen Knox, NIAO. The Chair noted that the Chief Executive would be late for this meeting.

2.0 Declaration of Interests

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

3.0 Chairman's Business

3.1 The Chair advised that the Standing Orders were approved by the Board on 16 May 2019 and will be made available on RQIA's website.

3.2 The Chair advised that he met with Ciara Flanagan, BSO Senior Client Accountant on 14 May 2019 to discuss the draft final accounts 2018/19.

3.3 The Chair advised Committee members of a circular relating to Guidance for laying, Presenting and Depositing of Papers in the Northern Ireland Assembly. The Chair advised that the circular has been shared with RQIA's Communications team.

3.4 The Chair advised Committee members that a letter from the BSO Chief Executive was received providing provisional assurances to the Chief Executive.

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

4.0 Minutes of previous meeting (AC/Min19/May)

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

4.1 Committee members **APPROVED** the minutes of the meeting of 2 May 2019, for onward transmission to the Board on 4 July 2019.

4.2 **Resolved Action (397)**
Board & Executive Support Manager to bring the Audit Committee minutes of 2 May 2019 to the July meeting of the Board for noting.

4.3 The Chair noted that actions 390, 392, 393, 395 remain on the action list. All other actions are complete.

4.4 POC asked for an update in relation to Drumclay Nursing Home. The Chief Executive advised Committee members that an application for registration has been received. The Responsible Individual interview is due to take place at the end of June 2019.

4.5 POC asked for an update in relation to 7.2 of the previous minutes, advertisement of new posts. JL advised that eight posts were advertised during May and closed on 4 June. Shortlisting has been completed and it is anticipated that the interviews for the Business Manager and Business Support Officers will be at the end of June. The interviews for the personal assistants, team supervisor and information analyst will take place in July.

4.6 JL advised Board members that in respect of Controls Assurance Standards RQIA have been in regular contact with the DoH. JL advised that the Small Agencies Corporate Forum are arranging a workshop to develop replacement checklists.

4.7 Catherine McKeown advised that section 10.15 of the minutes should reflect approved rather than noted.

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

5.0 Chief Executive Update on key risks

5.1 The Chief Executive informed members that since the last Audit Committee she has been in regular contact with Four Seasons Health Care, HSCB, DoH and trusts in relation to the pending sale of Four Seasons Health Care. The Chief Executive advised that Four Seasons Healthcare will be receiving indicative bids in the first instance. A meeting has been arranged for 8 July.

5.2 The Chief Executive advised that a workshop was convened with CPEA on 12 June.

5.3 The Chief Executive advised that there are no further updates in relation to the pre-judicial review challenge of the registration of Meadow View (formerly Ashbrooke) and in respect of two legal claims relating to a family member of Dunmurry Manor Care Home and a previous staff member.

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

6.0 Annual Report and Accounts 2018-19

6.1 The Chair advised that the draft Annual Report was shared with Board members in May. The Chair commented on the presentation of the work of RQIA throughout the year and that it is a beneficial way to communication the good work. GMcC agreed that the improved presentation enables more readable information.

6.2 Ciara Flanagan, BSO Senior Client Accountant, advised that RQIA achieved breakeven at 31 March 2019 with a £2.5K surplus. BSO Senior Client Accountant advised that RQIA met its target for prompt payments both 10 and 30 days.

6.3 The Chair thanked all members and officers for the work on the Annual Report and Accounts 2018/19. The Chair thanked Ciara Flanagan, BSO Senior Client Accountant for her work.

6.4 Audit and Risk Committee members **APPROVED** the Annual Report and Accounts 2018/19.

7.0 Corporate Risk Assurance Framework Report

7.1 The Head of Business Support advised that the Corporate Risk Assurance Framework Report remains unchanged from the Board on 16 May 2019.

7.2 The Head of Business Support advised Committee members that RQIA are currently considering a risk in relation to the upcoming implementation of the Mental Capacity Act, Deprivation of Liberty Safeguards in October. The Head of Business Support advised that RQIA are seeking urgent clarity on the scope of RQIA, as it is unclear in the regulations and code of practice.

7.3 GMcC asked if the Mental Capacity Act was applicable to Northern Ireland only and whether there was similar legislation in England, Scotland or Wales. The Head of Business Support advised that the Northern Ireland Act has been developed based on legislation developed for England, however the legislation has been rewritten and was approved on 13 June.

7.4 The Head of Business Support advised that a meeting is scheduled for 5

July with the DoH to ascertain further clarity on the role of RQIA. The Head of Business Support advised that a paper will be presented to the Board on 4 July in respect of the Mental Capacity Act.

7.5 **Resolved Action (398)**
A paper in respect of the Mental Capacity Act, Deprivation of Liberty Safeguards will be presented to the Board on 4 July.

7.6 The Chair asked Internal and External Audit for their views on the risks identified. DL, External Audit advised that the number of risks is manageable for the size of the organisation and that risks have been de-escalated to directorate risk registers.

7.7 Committee members **NOTED** the Corporate Risk Assurance Framework Report, for onward approval to the Board.

7.8 **Resolved Action (399)**
The Corporate Risk Assurance Framework Report to be presented to the July meeting of the Board for approval.

8.0 Risk Management Strategy

8.1 The Head of Business Support advised that the Board and Executive Support Manager has rewritten the Risk Management Strategy to reflect the ISO 31000:2018 standard. The Head of Business Support advised that the strategy for 2019-20 clearly outlines the Risk Management process for RQIA.

8.2 The Chair advised that he welcomes the initiative from the Board and Executive Support Manager to take forward the changes outlined in the document. The Chair advised that he reviewed the document before issuing with the papers and a few changes recommended.

8.3 GMcC commented that it is welcomed that the Risk Management Strategy reflects that risk is the responsibility of all staff within RQIA.

8.7 Committee members **APPROVED** the Risk Management Strategy, for onward approval by the Board.

8.8 Resolved Action (400)
Risk Management Strategy to be presented to the Board on 4 July 2019 for approval.

9.0 External Audit Update

- **Report to those Charged with Governance**

9.1 Denver Lynn (DL), External Audit advised that NIAO have sub-contracted the audit to Moore Stephens to complete the audit, however formal certification will be received from the Comptroller and Auditor General, NIAO.

9.2 Rosemary Peters-Gallagher (RPG), Moore Stephens, advised that the Report to those Charged with Governance remains in draft until final certification is received from the Comptroller and Auditor General. RPG advised of minor presentational issues that have been identified by the auditor and amended by BSO Senior Client Accountant.

9.3 RPG advised Committee members that no significant risks have been identified. RPG advised of a breakeven as at 31 March 2019 with a surplus of £2,403. RPG noted that recommendations from 2017/18 are now complete.

9.4 The Chair thanked all Committee members, Officers of the Committee, Internal and External Audit for their contribution to the audit and the development of the report and achieving an unqualified report.

9.5 Committee members **NOTED** the External Audit Update.

10.0 Standing Reports to Audit Committee
To include:

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

10.1 The Head of Business Support informed Committee members that no concerns have been raised under the Whistleblowing Policy to date during 2019/20.

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

10.3 The Head of Business Support informed Committee members that no acts of Fraud of Bribery have been identified to date during 2019/20.

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

10.5 The Head of Business Support advised Committee members that to date in 2019/20 that RQIA has not awarded any Direct Award Contracts.

10.6 The Head of Business Support informed Committee members that to date in 2019/20 that RQIA has not engaged External Consultants in this period.

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

10.8 The Head of Business Support asked members to note the Circulars issued by DoH which have no impact on RQIA Audit Committee.

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

11.0 Any Other Business

11.1 The Chair advised that the update on the Chief Executives key risks would be circulated within the minute prior to the next meeting.

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

Date of Next Meeting: **Thursday 19 October 2019, RQIA Boardroom, 10:00am**

The Regulation and Quality Improvement Authority

ACTION LIST

RQIA Audit Committee Meeting14 June 2019

Action	Minutes Ref	Agreed Action	Responsible Person	Due date for completion	Status
390 (Replaced action 383)	4.5	Draft Records Management Policy to be presented to Audit Committee in October 2019.	Head of Business Support	17 October 2019	
392	6.10	Directorate Risk Registers to be presented to Audit Committee for information on a rolling basis.	Board and Executive Support Manager	17 October 2019 (and ongoing)	
393	7.5	RQIA Contracts Register and register of all DAC's to be presented to Audit Committee on a six monthly basis.	Board and Executive Support Manager	17 October 2019 (and ongoing)	
395 (*replaced action 384)*	13.2	The National Fraud Initiative Report to be shared with Audit Committee when received.	Board and Executive Support Manager	17 October 2019	
396	14.5	Suggested amendments to the Standing Orders to be made prior to approval by the Board on 16 May 2019.	Board and Executive Support Manager	16 May 2019	

397	4.2	Board & Executive Support Manager to bring the Audit Committee minutes of 2 May 2019 to the July meeting of the Board for noting.	Business Manager	4 July 2019	
398	7.5	A paper in respect of the Mental Capacity Act, Deprivation of Liberty Safeguards will be presented to the Board on 4 July.	Head of Business Support	4 July 2019	
399	7.8	The Corporate Risk Assurance Framework Report to be presented to the July meeting of the Board for approval.	Head of Business Support	4 July 2019	
400	8.8	Risk Management Strategy to be presented to the Board on 4 July 2019 for approval.	Head of Business Support	4 July 2019	

Key

Behind Schedule	
In Progress	
Completed or ahead of Schedule	

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

This statement concerns the condition of the system of internal governance in the *Regulation and Quality Improvement Authority (RQIA)]* as at **18 October 2019**.

The scope of my responsibilities as Accounting Officer for *RQIA*, the overall assurance and accountability arrangements surrounding my Accounting Officer role, the organisation's business planning and risk management, and governance framework, remain as set out in the Governance Statement which I signed on 3 June 2019. The purpose of this mid-year assurance statement is to attest to the continuing effectiveness of the system of internal governance. In accordance with Departmental guidance, I do this under the following headings.

1. Governance Framework

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

2. Assurance Framework

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

3. Risk Register

I confirm that the Corporate Risk Assurance Framework Report has been regularly reviewed by the board of the organisation and that risk management systems/processes are in place throughout the organisation. As part of the board-led system of risk management, the Register is presented to the Audit and Risk Committee and the Board for discussion and approval and all significant risks are reported to the Board – most recently on 17 October 2019.

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

4. Performance against Business Plan Objectives/Targets

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

5. Finance

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

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

- safeguarding funds and ensuring that they are applied only to the purposes for which they were voted;
- seeking Departmental approval for any expenditure outside the delegated limits in accordance with Departmental guidance;

- preparation of business cases for all expenditure proposals in line with Northern Ireland Guide Expenditure Appraisal and Evaluation (NIGEAE) and Departmental guidance and ensuring that the organisation's procurement, projects and processes are systematically evaluated and assessed;
- accounting accurately for the organisation's financial position and transactions;
- securing goods and services through competitive means unless there are convincing reasons to the contrary; and
- procurement activity should be carried out by means of a Service Level Agreement with a recognised and approved Centre of Procurement Expertise (CoPE)

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

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

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

   Not applicable.

8. **External Audit Reports**

   There were no recommendations made by external audit.

9. **Internal Audit**

   I confirm the ongoing implementation of the accepted recommendations made by internal audit which have an implementation date of December 2019 and March 2020. However there is one priority two recommendation where the date of implementation was not met and relevant actions have been taken to ensure these recommendations are completed within a re-specified timeframe. Progress

continues to be monitored by the Audit Committee, most recently on 17 October 2019, through the Audit Action Plan.

10. RQIA and Other Reports

Not applicable.

11. NAO Audit Committee Checklist

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

12. Board Governance Self-Assessment Tool

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

13. Internal Control Divergences

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

Issue

As a consequence of our greater & deliberate emphasis on evaluating the well-led domain of care, we have taken an increased volume and complexity of enforcement

action this year. This has impacted on inspectors' availability for routine – low-risk – inspections and as a result we may not meet the minimum frequency across all low-risk establishments and agencies.

Response

A risk-based plan has been put in place in order to recover the position by the end of Q1 2020.

Issue

There has been an increase in unplanned, complex, multi-disciplinary inspections required in high-risk services – specifically in MHLD & children's acute care. Findings have centred on high-risk issues of governance as well as deficiencies in care delivery. As a result the quality assurance of a number of inspection reports has fallen behind schedule meaning that reports remain unpublished.

Response

A recovery plan for the publication of a backlog of reports within the Improvement Directorate was presented to the Board in September and will be monitored through EMT.

Issue

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

Response

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

Issue

BSO is responsible for providing RQIA with a range of services through Service Level Agreements (SLAs). The Head of Internal Audit presented the HIA Annual Report on the system of internal control for the year ended 31 March 2019 to the RQIA Audit Committee. However, to date, significant weaknesses in control continue to be identified in the audits relating to Payroll Shared Services.

Response

BSO's Management have accepted all of the recommendations in the Payroll Shared Services audit report and have agreed a range of actions to address these control weaknesses. BSO Internal Audit completed a further audit of Payroll Shared Services in 2019/20 and its findings will be reported to the RQIA Audit Committee.

Issue

In the RQIA inspection process, the quality assurance process should be enhanced to include a full review of the inspection file in addition to the draft report. This review should be evidenced. Records to be reviewed should be selected by the reviewer in all instances.

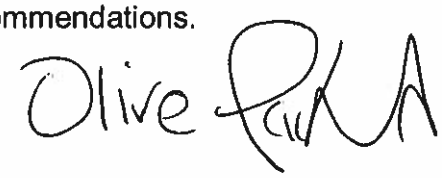
Response

RQIA management have accepted the recommendation. RQIA has developed an action plan in order to review progress of all recommendations of the Inspections 2018/19 report. The recommendation will inform development of our new QA process. The peer review procedure will be enhanced to reflect the following:

- For reports reviewed by an SI or AD, the reviewer will select the reports to be reviewed
- For peer review reports, reports will be selected by the relevant SI and allocated to a colleague
- Reports will be reviewed against an agreed template
- 1/3 of QA'd reports will be reviewed by a relevant reviewer from another team
- The review will correlate report findings with inspection record content

14. Mid-year assurance report from Chief Internal Auditor

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

Signed:  *Date:* 18 October 2019

CHIEF EXECUTIVE & ACCOUNTING OFFICER

The Regulation and Quality Improvement Authority

RQIA Board Meeting

Date of Meeting	21 November 2019
Title of Paper	Board Self-Assessment
Agenda Item	11
Reference	M/09/19
Author	RQIA Board
Presented by	Acting Chair
Purpose	This self-assessment tool is intended to help Arm's Length Bodies (ALBs) improve the effectiveness of their Board and provide the Board members with assurance that it is conducting its business in accordance with best practice**.**
Executive Summary	The public need to be confident that ALBs are efficient and delivering high quality services. The primary responsibility for ensuring that an ALB has an effective system of internal control and delivers on its functions; other statutory responsibilities; and the priorities, commitments, objectives, targets and other requirements communicated to it by the Department rests with the ALB's board. The Board is the most senior group in the ALB and provides important oversight of how public money is spent. It is widely recognised that good governance leads to good management, good performance, good stewardship of public money, good public engagement and, ultimately, good outcomes. Good governance is not judged by 'nothing going wrong'. Even in the best boards and organisations bad things happen and board effectiveness is demonstrated by the appropriateness of the response when difficulties arise. Good governance best practice requires Boards to carry out a board effectiveness evaluation annually, and with independent input at least once every three years.

FOI Considerations	None
Equality Impact Assessment	Not applicable
Recommendation/ Resolution	The Board is asked to **APPROVE** the Board Self-Assessment.
Next steps	None

BOARD GOVERNANCE SELF ASSESSMENT TOOL

For use by Department of Health Sponsored Arms Length Bodies

2018/19

Contents

1.Board Composition and Commitment

2. Board evaluation, development and learning

3. Board Insight and foresight

4. Board Engagement and Involvement

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Introduction

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

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

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

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

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

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

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

Application of the Board Governance Self-Assessment

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

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

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

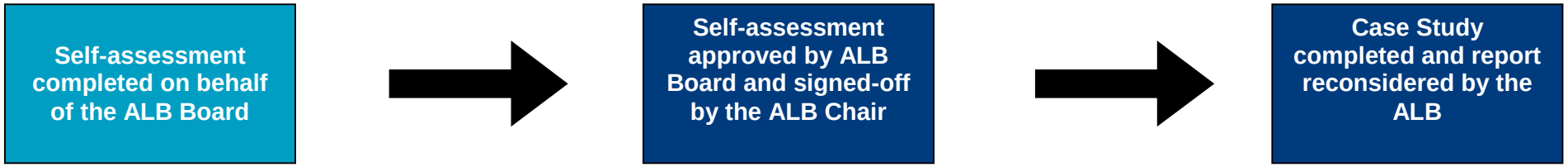
Complete the self-assessment: It is recommended that responsibility for completing the self-assessment sits with the Board and is completed section by section with identification of any key risks and good practice that the Board can evidence. The Board must collectively consider the evidence and reach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

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

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

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

Overview



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

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

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

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

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

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

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

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

Step 1

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

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

Step 2

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

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

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

Step 3

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

Scoring Criteria

The scoring criteria for each section is as follows:

Green if the following applies:

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

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

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

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

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

Red if the following applies:

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

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

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

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

1. Board composition and commitment

1. Board composition and commitment overview

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

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

1. Board composition and commitment

1.1 Board positions and size

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

1. Board composition and commitment

1.2 Balance and calibre of Board members

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

1. Board composition and commitment

1.3 Role of the Board

Red Flag	Good Practice
1. The Chair looks constantly to the Chief Executive to speak or give a lead on issues. 2. The Board tends to focus on details and not on strategy and performance. 3. The Board become involved in operational areas. 4. The Board is unable to take a decision without the Chief Executive's recommendation. 5. The Board allows the Chief Executive to dictate the Agenda. 6. Regularly, one individual Board member dominates the debates or has an excessive influence on Board decision making.	1. The role and responsibilities of the Board have been clearly defined and communicated to all members. 2. Board members are clear about the Minister's policies and expectations for their ALBs and have a clearly defined set of objectives, strategy and remit. 3. There is a clear understanding of the roles of Executive officers and Non Executive Board members. 4. The Board takes collective responsibility for the performance of the ALB. 5. NEDs are independent of management. 6. The Chair has a positive relationship with the Minister and sponsor Department. 7. The Board holds management to account for its performance through purposeful, challenge and scrutiny. 8. The Board operates as an effective team. 9. The Board shares corporate responsibility for all decisions taken and makes decisions based on clear evidence. 10. Board members respect confidentiality and sensitive information. 11. The Board governs, Executives manage. 12. Individual Board members contribute fully to Board deliberations and exercise a healthy challenge function. 13. The Chair is a useful source of advice and guidance for Board members on any aspect of the Board. 14. The Chair leads meetings well, with a clear focus on the issues facing the ALB, and allows full and open discussions before major decisions are taken. 15. The Board considers the concerns and needs of all stakeholders and actively manages it's relationships with them. 16. The Board is aware of and annually approves a scheme of delegation to its committees.

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

1. Board composition and commitment

1.4 Committees of the Board

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

1. Board composition and commitment

1.5 Board member commitment

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

2. Board evaluation, development and learning

2. Board evaluation, development and learning overview

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

1. Effective Board-level evaluation;

2. Whole Board Development Programme;

3. Board induction, succession and contingency planning;

4. Board member appraisal and personal development.

2. Board evaluation, development and learning

2.1 Effective Board level evaluation

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

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

2. Board evaluation, development and learning

2.2 Whole Board development programme

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

2. Board evaluation, development and learning

2.3 Board induction, succession and contingency planning

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

2. Board evaluation, development and learning

2.4 Board member appraisal and personal development

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

3. Board insight and foresight

3. Board insight and foresight overview

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

1.Board Performance Reporting

2.Efficiency and productivity

3.Environmental and strategic focus

4.Quality of Board papers and timeliness of information

3. Board insight and foresight

3.1 Board performance reporting

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

3. Board insight and foresight

3.2 Efficiency and Productivity

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

3. Board insight and foresight

3.3 Environmental and strategic focus

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

3. Board insight and foresight

3.4 Quality of Board papers and timeliness of information

Red Flag	Good Practice
1. Board members do not have the opportunity to read papers e.g. reports are regularly tabled on the day of the Board meeting and members do not have the opportunity to review or read prior to the meeting. The volume of papers is impractical for proper reviewing. 2. Board discussions are focused on understanding the Board papers as opposed to making decisions. 3. The Board does not routinely receive assurances in relation to Data Quality or where reports are received, they have highlighted material concerns in the quality of data reporting. 4. Information presented to the Board lacks clarity, or relevance; is inaccurate or untimely; or is presented without a clear purpose, e.g. is it for noting, discussion or decision. 5. The Board does not discuss or challenge the quality of the information presented or, scrutiny and challenge is only applied to certain types of information of which the Board have knowledge and/or experience, e.g. financial information	1. The Board can demonstrate that it has actively considered the timing of the Board and Committee meetings and presentation of Board and Committee papers in relation to month and year end procedures and key dates to ensure that information presented is as up-to-date as possible and that the Board is reviewing information and making decisions at the right time. 2. A timetable for sending out papers to members is in place and adhered to. 3. Each paper clearly states what the Board is being asked to do (e.g. noting, approving, decision, and discussion). 4. Board members have access to reports to demonstrate performance against key objectives and there is a defined procedure for bringing significant issues to the Board's attention outside of formal meetings. 5. Board papers outline the decisions or proposals that Executive Directors have made or propose. This is supported; where appropriate, by: an appraisal of the relevant alternative options; the rationale for choosing the preferred option; and a clear outline of the process undertaken to arrive at the preferred option, including the degree of scrutiny that the paper has been through. 6. The Board is routinely provided with data quality updates. These updates include external assurance reports that data quality is being upheld in practice and are underpinned by a programme of clinical and/or internal audit to test the controls that are in place. 7. The Board can provide examples of where it has explored the underlying data quality of performance measures. This ensures that the data used to rate performance is of sufficient quality. 8. The Board has defined the information it requires to enable effective oversight and control of the organisation, and the standards to which that information should be collected and quality assured. 9. Board members can demonstrate that they understand the information presented to them,

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

3. Board insight and foresight

3.5 Assurance and risk management

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

4. Board engagement and involvement

4. Board engagement and involvement overview

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

1.External Stakeholders

2.Internal Stakeholders

3.Board profile and visibility

4. Board engagement and involvement

4.1 External stakeholders

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

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

Red Flag	Good Practice
1. The development of the Business Plan has only involved the Board and a limited number of ALB staff. 2. The ALB has poor relationships with external stakeholders, with examples including clients, client organisations etc. 3. Feedback from clients is negative e.g. complaints, surveys and findings from regulatory and review reports. 4. The ALB has failed to manage adverse negative publicity effectively in relation to the services it provides in the last 12 months. 5. The Board has not overseen a system for receiving, acting on and reporting	1. Where relevant, the Board has an approved PPI consultation scheme which formally outlines and embeds their commitment to the involvement of service users and their carers in the planning and delivery of services. 2. A variety of methods are used by the ALB to enable the Board and senior management to listen to the views of service users, commissioners and the wider public, including 'hard to reach' groups like non-English speakers and service users with a learning disability. The Board has ensured that various processes are in place to effectively and efficiently respond to these views and can provide evidence of these processes operating in practice. 3. The Board can evidence how key external stakeholders (e.g. service users, commissioners and MLAs) have been engaged in the development of their business plans for the ALB and provide examples of where their views have been included and not included in the Business Plan. 4. The Board has ensured that various communication methods have been deployed to ensure that key external stakeholders understand the key messages within the Business Plan.

outcomes of complaints.	5. The Board promotes the reporting and management of, and implementing the learning from, adverse incidents/near misses occurring within the context of the services that they provide 6. The ALB has constructive and effective relationships with its key stakeholders.
Examples of evidence that could be submitted to support the Board's RAG rating.	• PPI features in business plan as a mainstream activity • Enforcement Policy and Procedures reviewed and RQIA role in handling complaints clarified • Approach to customer Survey is currently subject to review to ensure consistency • Regulatory and Review reports • External consultations on Corporate Strategy and the Fees & Frequencies Regulation

4. Board engagement and involvement

4.2 Internal stakeholders

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

4. Board engagement and involvement

4.3 Board profile and visibility

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

5. Board Governance Self- Assessment Submission

Name of ALB.....RQIA

Date of Board Meeting at which Submission was discussed…….....26 September 2019

Approved by Prof. Mary McColgan (ALB Acting Chair)

1. Board composition and commitment ALB Name RQIA Date 26 September 2019

1.1 Board positions and size

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1	See Standing Orders: Current list of Board members and Committees.			
GP2	Samples of last three Board and Audit Committee papers.			
GP3	See Standing Orders			
GP4	See Standing Orders			
GP5	There is a good mix of skills and knowledge. The Board is fully operational and delivering well in all areas. Although the majority of the Board is in post for 4 years, members are experienced and the Board is effective. RQIA has no control over the timing of future appointments but will seek to influence timely appointments to allow for succession planning.			

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	The Chair and/or CE are currently Acting or the position(s) vacant.	
RF2	The composition of the Board has two current vacancies	
RF3	The Board will regularly review the timing of future appointments for succession planning	

1. Board composition and commitment ALB Name RQIA Date 26 September 2019

1.2 Balance and calibre of Board members

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1	Descriptions of interests and background of Board members set out in Annual Reports and website.			
GP2	Descriptions of interests and background of Board members set out in Annual Reports and website.			
GP3	An equality scheme has been approved by the Board. Equality screening; RQIA is undertaking as appropriate and an Annual Report on S75 responsibilities is consistent and approved by the Board.			
GP4	Descriptions of interests and background of Board members set out in Annual Reports and website.			
GP5	Descriptions of interests and			

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

	financial management experience.			

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

1. Board composition and commitment ALB Name RQIA Date 26 September 2019

1.3 Role of the Board

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

GP4	Minutes of Board meetings. Quarterly review of Performance Framework.			
GP5	Minutes of Board meetings - demonstrates Board members independence and appropriate and robust challenges. All Board members are Non-Executive in keeping with statutory requirements.			
GP6	Minutes of Accountability Review meetings. Acting Chair's Appraisal.			
GP7	Minutes of Board meetings with particular reference to discussions on Corporate Performance and Risk Management reports.			
GP8	Minutes of Board and Committee meetings.			
GP9	Minutes of Board meetings.			
GP10	RQIA policies relating to Data Security. Nolan principles are contained within RQIA's Standing Orders.			

GP11	Minutes of Board meetings. All Board members are Non-Executive in keeping with statutory requirements.			
GP12	Minutes of Board meetings.			
GP13	Affirmed as positive by Board members in discussion for this report.			
GP14	Affirmed as positive by Board members in discussion for this report. Former workshop meetings now set as additional monthly meetings.			
GP15	Board Minutes. Consultations when preparing Corporate Strategy 2017-21 and the impact of the Programme for Government. March 2017 . Acting Chair participated in and attended internal and external stakeholder meetings.			
GP16	Standing orders approved in May 2019			

GP17	Corporate Performance Reports on progress on major programmes of work and specific updates to the Board as required. Post project evaluations are carried out in accordance with Departmental guidance.			

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

1. Board composition and commitment ALB Name RQIA Date 26 September 2019

1.4 Committees of the Board

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

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

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

1. Board composition and commitment ALB Name RQIA Date 26 September 2019

1.5 Board member commitment

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1	A register of Board and Committee Attendance is maintained.			
GP2	Input to committees discussed at Board meetings and formal process adopted. Terms of reference of Committee. Appraisal of Board members. There is commitment beyond Board Meetings and Committees of the Board in respect of participation in review planning, participation in inspection visits, adhoc meetings and workshops.			
GP3	Standing Order 6 and incorporated into Induction Programme.			
GP4	Schedule of meetings for 2019-20 has been confirmed. A schedule for			

	2020-21 will be issued in line with 6 month notice period.			

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

2. Board evaluation, development and learning ALB Name RQIA Date 26 September 2019

2.1 Effective Board level evaluation

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

	were implemented by year end 2017-18.			
GP4	Internal audit review on Board Effectiveness and Performance Management undertaken in 2017. Actions were implemented by year end 2017-18.			
GP5	Board Standing Orders **(May 2019)** and Management Statement and Financial Memorandum (October 2018) in place and currently with the DoH for review. Board Standing Orders revised and updated **May 2019** Board secretariat reviewed and additional capacity provided. All Board meetings are open to the public and are advertised as such. Board and Committee minutes formally approved by RQIA Board and made available on RQIA website. Action list included with minutes of future Board meetings.			

GP6				

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

2. Board evaluation, development and learning ALB Name RQIA Date 26 September 2019

2.2 Whole Board development programme

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

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

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

2. Board evaluation, development and learning ALB Name RQIA Date 26 September 2019

2.3 Board induction, succession and contingency planning

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

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

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

2. Board evaluation, development and learning ALB Name RQIA Date 26 September 2019

2.4 Board member appraisal and personal development

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1	Individual Board Member appraisals undertaken.	Common areas for development should inform Board development program as at 2.2/GP6.		
GP2	All Board members are Non-Executive in keeping with statutes establishing the organisation.			
GP3	Appraisal process undertaken as set by Permanent Secretary.			
GP4	Board member objectives linked to Business Plan.			
GP5	PDP developed for each Board Member.			
GP6	Board Members contribution to committees, panels and stakeholders involvement is noted.			
GP7	Professional CPD requirements, where			

	relevant, are met			

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

3. Board insight and foresight ALB Name RQIA Date 26 September 2019

3.1 Board performance reporting

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1	The annual Business Plan sets out the Key Performance Indicators and the Board is apprised regularly through the Corporate Performance Report.			
GP2	Board receives Corporate Performance Report quarterly. The performance report has been enhanced during this reporting period.			
GP3	Chairs of both Audit Committee and Remuneration Committee report to the Board. Updates are also provided from Chairs of Panels as required.			
GP4	Key risks are discussed at Board and Audit Committee as part of the presentation and update of the Corporate Risk Assurance Framework.			

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

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

3. Board insight and foresight ALB Name RQIA Date 26 September 2019

3.2 Efficiency and Productivity

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

	The Board approved cost reduction plans in response to DOH austerity measures.			
GP3	Improvement and Efficiency Plans are incorporated into Corporate Performance Report which is BRAG Rated.			
GP4	The progress of the service delivery plan is included in the Corporate Performance Report, on a quarterly basis.			

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

3. Board insight and foresight ALB Name RQIA Date 26 September 2019

3.3 Environmental and strategic focus

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

GP3	The Executive Management Team in collaboration with staff prepared a draft Business Plan. Annual Business plan for 2019-20 was brought to and approved at the **March 2019** Board meeting.			
GP4	The key performance indicators set out in the Business plan are monitored by the Board through the Corporate Performance Report.			
GP5	An enhanced Corporate Risk Assurance Framework report was approved by the Board following consultation with the Executive Management Team. In support of the Business Plan, an Annual Horizon Scanning exercise supported by a PESTLE analysis provides for a review of environmental and strategic risks impacting RQIA.			

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

RF2		
RF3		

3. Board insight and foresight ALB Name RQIA Date 26 September 2019

3.4 Quality of Board papers and timeliness of information

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

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

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

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

3. Board insight and foresight ALB Name RQIA Date 26 September 2019

3.5 Assurance and risk management

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

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

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

4. Board engagement and involvement ALB Name RQIA Date 26 September 20194.1 External stakeholders

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1	RQIA 2017-21 Strategy focuses on service users and carers and has been updated to reflect the Programme for Government outcomes			
GP2	Recruitment of lay assessors in Mental Health, Regulation and in Review Programme. Consultation with advocacy groups in Mental Health and Learning Disability. Easy read versions of inspection reports have been implemented across the inspection teams RQIA leadership continues to engage with Commissioner for Older People, Children's Commissioner and the Ombudsman.	The RQIA Communications and Engagment strategy has been developed during 2018-19.		

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

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

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

4. Board engagement and involvement ALB Name RQIA Date 26 September 2019

4.2 Internal stakeholders

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

	monitored by the Board through a key performance indicator.			
GP4				
GP5	RQIA reviewed its values during 2018-19. . Key learning from whistleblowing investigation findings were disseminated to staff. RQIA has a suite of policies and procedures available on the intranet for all staff members.			
GP6	RQIA has a Risk Management Strategy and risk management protocol in place at corporate, project and Directorate levels.			

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

4. Board engagement and involvement ALB Name RQIA Date 26 September 2019

4.3 Board profile and visibility

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1	Board members are invited to experience the process of inspection by accompanying inspectors or are invited to be part of the quality assurance of review reports.			
GP2	Board members attend NICON Conferences to increase their profile and their learning regarding key strategic issues. The Acting Chair and Chief Executive meet regularly with the leadership of trusts and relevant ALBs.			
GP3	Board members attended and presented at consultation events in the Corporate Strategy 2017-21.			
GP4				
GP5	Minutes of RQIA Board meetings are available on			

	the RQIA website. Board meetings are open to the public.			
GP6	Board members have personal appraisal processes which include feedback.			

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	A non-executive lead for HSC PPI is required	
RF2		

Summary Results **ALB Name RQIA Date 26 September 2019**

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

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

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

3.5 Assurance and risk management	Green	

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

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

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

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

6. Board impact case studies

6. Board impact case studies

Overview

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

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

2. Organisational culture change; and

3. Organisational strategy.

6. Board impact case studies

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

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

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

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

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

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

6. Board impact case studies ALB Name RQIA Date 26 September 2019

6.1 Case Study 1

Performance Failure in Assurance Directorate :

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

The publication of COPNI's 'Home Truths' Report on Dunmurry Care Home on 13th June 2018 made 59 recommendations specific to RQIA across nine themes including safeguarding and human rights, care and treatment of residents, regulation and inspection, complaints and communication and accountability and governance.

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

The publication of the report was critical about RQIA's inspection processes and governance; the attendant high profile media attention was impacting on RQIA's reputation and public perception of RQIA's role.
Board was concerned about the impact of the report on several fronts: the alleged failures of the inspection process, the governance procedures regarding regulation of residental homes,RQIA staff morale, impact public confidence in role of Regulator and significantly the impact on families and residents in DMCH and other homes managed by Runwood Homes. Following publication of the report, CEO had arranged for unannounced inspections of all Runwood homes to offer assurance that concerns related to DMCH were not reflected in other units..

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

CEO provided a comprehensive briefing paper (18/6/18) for an Extra Ordinary Board meeting on 21st June 2018 which was held to discuss the publication of the report. COE had appended RQIA's initial repose to recommendations (appendex A) and detailed DMCH action plan A] (appendex B) which outlined RQIA's internal learning, plans for RQIA's external focus, specific attention to Care Homes, HSCT Trusts, and Department

A subsequent Board workshop meeting on 3rd August considered issues related to the Rapid Review of DMCH, correspondence to PS and CSS and proposed TOR.

Area for focus	Specific Actions	Timescale	Lead responsible	Outcomes
Family concerns about relatives in care of Runwood Homes	Public meetings were held with families in each of the Runwood homes to address concerns and explain RQIA's role and responsibilities in relation to inspection	Summer and Autumn of 2018	CEO, Acting Chair and Director of Assurance	Total of 10 meetings were held across all homes in Runwood group
Employee relations and culture	Review of 'critical reflections' on RQIA's role were presented during learning week. Human Rights Training for all staff and Board members was organised.	November 2018	CEO and Board representatives	
Communication strategy related to findings of report and potential risk to reputational aspects	Develop robust communication and engagement strategy. Engage public representatives	CEO established new group involving public. Commissioned report from Clare Aiken regarding external perceptions of RQIA and ways to enhance public profile. Actions undertaken during August to Feb.	CEO, Head of Business Support and Board reps	Communication and Engagement Strategy agreed at Board in September.

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

Since the publication of ‘Home Truths’ RQIA’s has engaged in regular monitoring and review of the progress relating to the recommendations. The Board has been involved in meetings with CPEA regarding their regional review, COE and Acting Chair have met CPEA on three occasions in addition to engagement through board meeting and workshop. RQIA has introduced an new inspection methodology, developed a RADaR project to enhance identification of risks, established a weekly ‘Huddle Meetng’ to ensure an early alert system for raising concerns and highlighting patterns across services and the focus on performance has led to increased approaiction of how RQIA’s data base can support quality management.
CEO ,senior executive team and RQIA inspectors engaged in detailed ‘look back’ review of RQIA’s inspections and the learning was presented at a seminar during RQIA’s learning week in November 2018.

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

The Board was actively engaged in discussing the action to be taken to be taken in the action plan, contributed to RQIA’s response to COPNI recommendations which was fed through to DH as a Corporate regional response had been the agreed action , two Board representatives attended meeting with PS to discuss RQIA’s report and CEO and Acting Chair attended a further meeting with PS to discuss report complied by RQIA to highlight factual inaccuracies.