The Regulation and Quality Improvement Authority

AGENDA

RQIA Board Meeting
Board Room, RQIA, 9th Floor, Riverside Tower, Belfast
11 March 2014, 1.35pm

PUBLIC SESSION

	Item	Paper Ref	
1	Welcome and Chairman's remarks		**1.35pm**
2	Minutes of the meeting of the Board held on Thursday 16 January 2014	**min/Jan14/ public**	**1.40pm APPROVE**
3	Matters arising from minutes		**1.45pm NOTE**
4	Declaration of Interests		**1.55pm**
5	Chairman's report **Chairman**	**A/02/14**	**2.00pm NOTE**
6	Chief Executive's Report **Chief Executive**	**B/02/14**	**2.10pm NOTE**
7	Finance Report **Director of Corporate Services**	**C/02/14**	**2.30pm NOTE**
8	Corporate Performance Report **Director of Corporate Services**	**D/02/14**	**2.45pm APPROVE**
9	Corporate Risk Assurance Framework Report **Director of Corporate Services**	**E/02/14**	**3.00pm APPROVE**
10	Draft RQIA Strategy Map 2015-18 **Director of Corporate Services**	**F/02/14**	**3.15pm APPROVE**
11	Proposal to Develop a Corporate Scorecard **Director of Corporate Services**	**G/02/14**	**3.30pm APPROVE**
12	Audit Committee Business **Committee Chairman**		**3.45pm**
	To include:		
	• Approved Minutes of meeting of 24 October	**H/02/14**	**NOTE**
	• Verbal update on Meeting of 27 February		**NOTE**

13	Board Governance self-assessment tool **Chairman**	**I/02/14**	**4.00pm** **APPROVE**
14	Any Other Business		**4.15pm**

Date of next meeting:
Thursday 15 May 2014, Boardroom, RQIA

The Regulation and Quality Improvement Authority

RQIA Board Meeting

Date of Meeting	11 March 2014
Title of Paper	Public Session Minutes
Agenda Item	2
Reference	Min / Jan14 / public
Author	Katie Symington
Presented by	Dr Ian Carson
Purpose	To share with Board members a record of the previous meeting of the RQIA Board.
Executive Summary	The minutes contain an overview of the key discussion points and decisions from the Board meeting on 16 January 2014.
FOI Exemptions Applied	None
Equality Impact Assessment	Not applicable
Recommendation/ Resolution	The Board is asked to **APPROVE** the minutes of the Board meeting of 16 January 2014.
Next steps	The minutes will be formally signed off by the Chairman and will be uploaded onto the RQIA website.

PUBLIC SESSION MINUTES

RQIA Board Meeting
Board Room, A Floor, Belfast City Hospital
16 January 2014, 2.00pm

Present

Ian Carson (Chairman)
Sarah Havlin
Lindsey Smith
Daniel McLarnon
Patricia O'Callaghan
Denis Power
John Jenkins CBE
Una O'Kane
Geraldine Donaghy
Mary McColgan OBE

Officers of RQIA present

Glenn Houston (Chief Executive)
Maurice Atkinson (Director of Corporate Services)
Theresa Nixon (Director of Mental Health, Learning Disability and Social Work)
David Stewart (Director of Reviews and Medical Director)
Kathy Fodey (Director of Regulation and Nursing)

In attendance

Malachy Finnegan (Communications Manager)
Katie Symington (Board and Executive Support Manager)
Shirley Johnston (Practice Education Facilitator, NHSCT)

Apologies

Ruth Laird CBE
Patricia McCoy

14.7 Agenda Item 1 - Welcome and Chairman's remarks

14.7.1 The Chairman welcomed Board members, Officers of the Board and a member of the public to the meeting of the RQIA Board. The Chairman also welcomed Shirley Johnston, (NHSCT) who is on a Florence Nightingale scholarship and is shadowing Kathy Fodey, Director of Regulation and Nursing

Apologies were noted from Ruth Laird and Patricia McCoy.

The Chairman offered congratulations to Mary McColgan who has been awarded an OBE in the new year's honours list.

14.8 Agenda Item 2 - Minutes of the meeting of the Board held on 14 November 2013 (min/Nov13/public)

14.8.1 The Board **APPROVED** the minutes of the Board meeting held on 14 November 2013.

Board members noted the completed actions on the action plan. The Chief Executive informed Board members that actions 25 and 29 will be addressed at the February Board workshop.

Resolved Actions
Minutes to be formally signed off by the Chairman

14.9 Agenda Item 3 - Matters arising from minutes

14.9.1 Board members were advised that the advertisement for lay reviewers will be actioned by the Business Services Organisation on 21/ 28 January 2014.

14.9.2 The Board **NOTED** the matters arising from the public minutes.

14.10 Agenda Item 4 - Declaration of Interests

14.10.1 The Chairman asked Board 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.

14.10.2 The Chairman asked Board members to advise the Board & Executive Support Manager of any necessary updates to the Register of Interests.

14.11 Agenda Item 5 - Chairman's Report (A/07/13)

14.11.1 The Chairman informed Board members that no announcement has been made in relation to the new Board member appointments.

The Chairman noted his attendance at the NICE Board meeting on 20 November 2013.

The Chairman asked two Board members; Daniel McLarnon and Lindsey Smith to join himself, the Director of Corporate Services and the Board and Executive Support Manager in convening a short life working group to review the format of Board minutes.

The Chairman noted that the minutes of the Accountability meeting, 26 November 2013, have been circulated to Board members.

Resolved actions
Board and Executive Support Manager to convene a meeting of the short life working group

14.11.2 The Board **NOTED** the Chairman's Report.

14.12 Agenda Item 6 - Chief Executive's Report (B/07/13)

14.12.1 The Chief Executive notified the Board of the revised go-live date for the i-Connect system, 30 June 2014, to allow for data migration.

14.12.2 The Chief Executive highlighted to Board members the return to compliance of Autism Initiatives, domiciliary care service. Current enforcement action is contained in annex A of the report.

14.12.3 The Chief Executive noted the response received from Minister, dated 14 January, regarding the proposed extension of the terms of reference for the Review of Cherry Tree Nursing Home, which will allow the Review team to meet with the families of patients from this home.

The Chief Executive also noted the Child Sexual Exploitation Inquiry, led by Kathleen Marshall, and her intention to meet with parents and young people during her next visit to Belfast.

Board members were asked to note the further commissioned review of the actions set out in the Dental Hospital Inquiry Action Plan, published in July 2013.

The Chief Executive informed Board members that the draft report into the Oversight of Patient Finances in Residential Settings has been sent to the DHSSPS, and contains seven recommendations.

14.12.4 The Chief Executive informed Board members that letters of escalation have been issued to the Western Health and Social Care Trust, the South Eastern Health and Social Care Trust and the Northern Health and Social Care Trust, following inspections by the Mental Health team. These matters are being dealt with under the escalation process.

14.12.5 The Chief Executive noted the successful information sharing conference organised by the Mental Health and Learning Disability Team, which took place on 6 December 2013 and was attended by Consultant Psychiatrists and by other HSC employees.

14.12.6 The Chief Executive drew the Board's attention to one new complaint in relation to a staff member, and six whistleblowing disclosures.

14.12.7 The Chief Executive highlighted to Board members the media interest in relation to the work of RQIA.

12.12.8 The Chief Executive informed Board members of his involvement in the EPSO Peer Evaluation (Denmark) and noted that the completed report will be shared with Board members, on publication.

14.12.9 The Chief Executive noted the recent meeting with the Chief Executive and directors of the Health and Safety Executive NI and the agreement to hold regular meetings to discuss areas of mutual interest and concern.

14.12.10 The Board **NOTED** the Chief Executive's report.

14.13 Agenda Item 7 – Finance Report (C/07/13)

14.13.1 The Director of Corporate Services presented the Finance Report to Board members, which details RQIA's financial position at 30 November 2013.

The projected end of year position takes into account the non-recurring reduction of £66,000 in the Revenue Resource Limit and the £33,000 payment for BSTP project costs. The financial projection is dependent on securing DHSSPS funding for commissioned reviews. The current projected end of year position is £21,000 overspend.

14.13.2 The Director of Corporate Services highlighted the improved figures in relation to prompt payment compliance for the 30 day and 10 day targets.

14.13.3 The Director of Corporate Services informed Board members that £21,000 of debt remains outstanding at quarter three for the 2013-14 financial year, while there is no outstanding debt from previous financial years.

14.13.4 The Chief Executive informed Board members that he wrote to Julie Thompson, Senior Finance Director/ Deputy Secretary, DHSSPS on 2 December 2013 in relation to RQIA's financial pressures. A response was received from Julie Thompson, on 8 January 2014, noting the need to highlight financial pressures to RQIA's Sponsor Branch.

The Chief Executive noted that cost pressures were also highlighted at the November Accountability meeting with DHSSPS.

Clarification was provided to Board members that the tolerance level for breakeven is +/- 0.25% or +/- £20,000 whichever is the higher.

Resolved actions
The Chief Executive will respond to the letter of 8 January 2014, in conjunction with the Audit Committee Chair and the Director of Corporate Services.

14.13.5 The Board **NOTED** the Finance report.

14.14 Agenda Item 8 - Business Plan 2014-2015 (D/07/13)

14.14.1 The Director of Corporate Services presented the 2014-15 Business Plan to Board members. The DHSSPS date for submission for approval of the Business Plan is 17 January 2014.

Board members agreed that additional comments should be added to the introduction of the Business Plan, in relation to RQIA's financial allocation from DHSSPS and the current constraints within which RQIA operates.

Agreement that Denis Power and Dr John Jenkins will work with the Director of Corporate Services to strengthen the introduction to the Business Plan.

Resolved actions
The introduction to the Business Plan will be strengthened before submission to DHSSPS
Changes to the Business Plan to be communicated to Board members

14.14.2 Board members **APPROVED** the Business Plan.

14.15 Agenda Item 9A - Plan for the Development of the new Corporate Strategy 2015-18 (E/06/13)

14.15.1 The Director of Corporate Services presented the plan for the development of RQIA Corporate Strategy (2015-18) to Board members. Key dates were outlined to Board members, to include approval of the draft strategy at the July 2014 Board meeting and final approval of the strategy at the January 2015 Board meeting, following the consultation process.

A Steering Group of four Board members will be established, to include one new Board member. Board members noted that the Planning and Corporate Governance Manager will be leading the development of the new strategy. The Director of Corporate Services will develop the new Strategy map.

The Chairman appointed Denis Power, Daniel McLarnon and Professor Mary McColgan to the steering group.

14.15.2 Board members **APPROVED** the Plan for the Development of the new Corporate Strategy 2015-18.

14.16 Agenda Item 9B - Plan for the Development of the new Review Programme (F/07/13)

14.16.1 The Director of Reviews and Medical Director presented the Plan for the Development of the new RQIA Review Programme to Board members. The Director of Reviews and Medical Director noted that work will be undertaken with the DHSSPS in relation to commissioned reviews for the new Review programme.

Three Board members are requested to join the project team, one of which will be a new Board member, once appointed by the Minister.

The Chairman appointed Patricia O'Callaghan and Professor Mary McColgan to the project team.

14.16.2 Board members **APPROVED** the Plan for the Development of the new RQIA Review Programme.

14.17 Agenda Item 10 - Policies and Procedures for Part IV Doctors (G/07/13)

14.17.1 The Director of Mental Health, Learning Disability and Social Work outlined the role of Part IV Doctors for Board members and presented the policies and procedures for Part IV Doctors.
Currently RQIA has eight Part IV Doctors on the Part IV register.
Appointment to the list of Part IV Doctors will be on a four yearly basis.

14.17.2 The Chairman agreed that the Panel and Chairman for Part IV Doctors will remain consistent with the Part II Doctors. Other Board members may be asked to participate in these panels as necessary.

The Chairman noted that following appointment of the new Board members a refresh in committee structures will be necessary.

Resolved actions
Panel members to submit any final textual amendments to the policies and procedures for Part IV Doctors to the Director of Mental Health, Learning Disability and Social Work

14.17.3 Board members **APPROVED** the policies and procedures for Part IV Doctors.

14.18 Agenda Item 11 - Regulation Directorate Annual Report 2012-13 (H/07/13)

14.18.1 The Director of Regulation and Nursing tabled the Regulation Directorate Annual Report 2012-13. This report will be placed on the RQIA website, following receipt of comments from Board members, at the end of January 2014. This report will also be provided to DHSSPS.

The Chief Executive requested that this report is referenced at the Provider road shows to be held in February.

Resolved actions
Board members to submit comments on the Regulation Directorate Report 2012-13 to the Board and Executive Support Manager

14.8.2 Board members **NOTED** the Regulation Directorate Annual Report 2012-13.

14.19 Agenda Item 12 - Hygiene Report Overview 2012-13 (I/07/13)

14.19.1 The Director of Reviews and Medical Director presented the 2012-13 Overview Report to Board members. This report presents an improvement in compliance rates for inspected facilities.

Board members were asked to note page four of the report detailing changes to the inspection process and the development of a suite of audit tools for augmented care areas, including neonatal care and critical care.

The Director of Reviews and Medical Director noted that the next three year hygiene inspection programme will commence in conjunction with the three year review programme, in 2015. Board members were also asked to note that the next hygiene overview report will be amalgamated into RQIA's annual quality report, which will be presented to the Board in September 2014.

This report will be made available on the RQIA website.

A Board member suggested that the report should provide an indicative timeframe for hygiene reports to be uploaded onto the RQIA website.

The Chief Executive informed Board members that hygiene inspectors will be given the opportunity to go to Salford NHS Foundation Hospital Trust, as the highest rated NHS hospital, to observe their systems and processes.

The Chief Executive also noted an upcoming Institute of Healthcare Management event (June 2014) at which aspects of RQIA's work in respect of infection prevention will be presented to delegates.

14.19.2 Board members **NOTED** the Hygiene Report Overview 2012-13.

14.20 Agenda Item 13 – Any Other Business

14.20.1 The Chairman noted that the next Board workshop will be held on Thursday 13 February 2014, starting at 12.30pm.

The Chairman informed Board members that he has written to the Minister inviting him to meet the Board in the near future. The Chairman formally thanked the four Board members, whose tenure ends on 28 February 2014, in this their final Board meeting.

Board members agreed to the revised date of Thursday 15 May 2014 for the May Board meeting.

The member of the public was thanked for attending the meeting, and as they had no formal questions for the Board and the Executive Team the public session of the meeting was brought to a close at 4.15pm.

Date of next meeting:
Tuesday 11 March 2014, Boardroom, RQIA.

Signed _____

Dr Ian Carson
Chairman

Date _____

Board Action List

Action number	Board meeting	Agreed action	Responsible Person	Status
25	3 September 2013	The results of the Oval Mapping exercise will be shared with Board members	Chief Executive	Ongoing
29	3 September 2013	Risk Register to be reviewed by the Executive Management Team; two risks to be removed and strategic risks to be included	Chief Executive	Ongoing
34	14 November 2013	A paper on the implementation of RQIA recommendations following Review Reports will be provided to Board members	Chief Executive	Ongoing
36	16 January 2014	Minutes to be formally signed off by the Chairman	Chairman	Completed
37	16 January 2014	Board and Executive Support Manager to convene a meeting of the short life working group	Board and Executive Support Manager	Completed
38	16 January 2014	The Chief Executive will respond to the letter of 8 January 2014, in conjunction with the Audit Committee Chair and the Director of Corporate Services	Chief Executive	Ongoing
39	16 January 2014	The introduction to the Business Plan will be strengthened before submission to DHSSPS	Director of Corporate Services	Completed
40	16 January 2014	Changes to the Business Plan to be communicated to Board members	Director of Corporate Services	Completed
41	16 January 2014	Panel members to submit final textual amendments to the policies and procedures for Part IV Doctors to the Director of Mental Health, Learning Disability and Social Work	Part II/ IV Panel Members	Completed
42	16 January 2014	Board members to submit comments on the Regulation Directorate Report 2012-13 to the Board and Executive Support Manager	Board members	Completed

The Regulation and Quality Improvement Authority

RQIA Board Meeting

Date of Meeting	11 March 2014
Title of Paper	Chairman's Report
Agenda Item	5
Reference	A/02/14
Author	Dr Ian Carson
Presented by	Dr Ian Carson
Purpose	To inform the RQIA Board of the Chairman's external engagements and key meeting since the last Board meeting of the Authority.
Executive Summary	Between 16 January 2014 and 11 March 2014, I attended 8 meetings on behalf of RQIA.
FOI Considerations	None
Equality Impact Assessment	Not applicable
Recommendation/ Resolution	The Board is asked to **NOTE** this report.
Next steps	Not applicable

CHAIRMAN'S REPORT

Meetings attended

- Chairs Forum: Meeting with Simon Hamilton MLA, Minister of Finance. – 29 January 2014.
- Breakfast Seminar: Patient Safety, Dr Gavin Lavery – 28 January 2014.
- Breakfast Seminar: Thinking Differently about Safety, Julie Harries, NHS Improving Quality (NHSIQ) – 4 February 2014.
- Chair's Appraisal, DHSSPS – 11 February 2014.
- Meeting with Dr Gavin Lavery – 12 February 2014.
- Opening address on 'New Accountabilities' discussion group at Professional Standards Authority Symposium, London – 21/22 February 2014.
- Regulation and Improvement Forum, Civil Service Commissioners – 4 March 2014.
- NICON Conference – 5/6 March 2014.

DR IAN CARSON
Chairman

11 March 2014

The Regulation and Quality Improvement Authority

RQIA Board Meeting

Date of Meeting	11 March 2014
Title of Paper	Chief Executive's Report
Agenda Item	6
Reference	B/02/14
Authors	Glenn Houston
Presented by	Glenn Houston
Purpose	The purpose of the Report is to update the Board on strategic issues which the Chief Executive and Senior Management Team has been dealing with since the January Board meeting, and to advise Board members of other forthcoming key developments or issues.
Executive Summary	The matters highlighted in the Report include: • Strategic Developments or Issues • Significant Operational Issues or Risks • Corporate Governance Issues • Resource Issues (Finance and Human Resources) • Communications
FOI Exemptions Applied	None
Equality Impact Assessment	Not applicable
Recommendation/ Resolution	The Board is asked to **COMMENT** on the Chief Executive's Report.
Next steps	Not applicable

CHIEF EXECUTIVE'S REPORT

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1. Strategic Developments or Issues

1.1 Corporate Services

Corporate Strategy & Scorecard

Significant work has been undertaken since the previous Board meeting to develop a new draft Strategy Map 2015-18 and a proposal to develop a Corporate Scorecard. The Strategy Steering Group met for the first time on 27 February.

See Agenda items **F/02/14** and **G/02/14**.

Business Plan 2014/15

The draft Business Plan 2014/15 was submitted to the Department on 17 January following the Board meeting on 16 January at which the Plan was considered. We are awaiting DHSSPS approval of the Business Plan.

i-connect

The development of i-connect continues to progress well with a projected go-live date of 30 June 2014 for the core system. Preparation is underway for User Acceptance Testing (UAT) which is scheduled to take place in March/April. Internal Audit has been asked to provide assurances to the i-connect Project Board and Audit Committee about the robustness of the UAT process. A meeting of the i-connect Project Board took place on 6 March.

A risk to the project is the loss of the current Project Manager at the end of March. A range of options for the replacement of the Project Manager or extension of the current contract has been explored without success. This means that we propose to use the Technology Partner Agreement (TPA) to secure project management support for a period of 5-6 months. This will be subject to the approval of an Addendum to the current i-connect Business Case by DHSSPS.

IiP

A formal application has been made for IiP assessment in June.

Secondment

Christine Goan has been appointed to DHSSPS on a secondment basis for six months to work on incident reporting procedures. Jill Munce has been appointed on a temporary basis to replace Christine in the role of Corporate Improvement and Public Engagement Manager with effect from 1 March 2014.

1.2 Regulation

Inspection Activity

The last quarter of the year is particularly busy with inspectors undertaking such inspections as necessary to meet our statutory target. Estates, pharmacy and finance inspectors are providing support to ensure that each establishment or agency achieves the required number of inspections. Services subject to enforcement action, or where there are ongoing concerns, continue to receive inspections on a risk assessed basis.

Registration of Independent Clinics

Following receipt of legal advice on the definition of an independent hospital and an independent clinic, RQIA has initiated a review of independent clinics that should more appropriately be registered as ***independent hospitals providing prescribed techniques***.

We have written out to 32 services to notify them of this change and to issue new certificates. A further determination is still to be made regarding fee charges which is premised on clarification from DHSSPS as to the definition of an 'approved place'.

Independent Hospitals will, as before, receive a minimum of one inspection per annum against the Independent Healthcare Regulations (Northern Ireland) 2005.

Provider Information Events

During the month of February, RQIA organised and ran a series of provider roadshows to highlight lessons and outcomes from 2013/14 inspection year, and to share the inspection themes and standards for 2014/ 15.

These events, held at Mossley Mill and Oxford Island, were attended by more than 1100 service providers. Inspectors made presentations on care issues, finance, medicines management, estates and human rights concerns.

A number of service providers and external partners, such as the Royal College of Nursing, Public Health Agency and a disability charity participated, by making presentations on outcomes from enforcement action, and meaningful activities in day care.

Enforcement Activity Update

An update on enforcement activity is included at Appendix A.

1.3 Reviews

In January 2013, RQIA advertised publically for the recruitment of voluntary lay assessors to participate in the Review, Regulation and Mental Health programmes of inspection and review. Lay assessors are members of the public who can bring their own experience, fresh insight and a public focus to RQIA inspections and reviews.

Interviews with applicants will be held in the next few weeks and then training will be provided for the assessors who are appointed. The aim is to commence their involvement in the inspection and review programmes in 2014/15.

RQIA has continued to work on three additional commissioned reviews which commenced in 2013:

- The review of actions taken by relevant organisations in response to a whistle-blower and other allegations made concerning Cherry Tree House, a nursing and residential care home in Carrickfergus. Public Notices have been placed to enable any individual who had raised a concern about the service, during the period covered by the review, to bring this to the attention of RQIA.

- The Independent Inquiry into Child Sexual Exploitation. For this review a Call for Evidence will close on Tuesday 18 March 2014.

- A review to examine the implementation of actions set out in the Dental Hospital Inquiry Action Plan which was published in July 2013. The fieldwork for this review is being carried out from 1 to 3 March 2014.

Since the last Board meeting, RQIA was asked to carry out two additional commissioned exercises in relation to concerns about the provision of unscheduled care services in the Belfast Trust.

On 30 January 2014, RQIA was asked by the Minister to carry out an inspection of the Emergency Department and the Acute Medical Unit of the Royal Victoria Hospital at the earliest opportunity. This inspection was carried out by a team of RQIA inspectors from both the Review and Regulation Directorates, from 31 January 2014 to 3 February 2014. Preliminary feedback was provided to the Belfast Trust on 5 February 2014 and subsequently to the DHSSPS. A report of the inspection is being prepared.

On 17 February 2014, RQIA was requested by the Chief Medical Officer to carry out a review of the arrangements for the management and co-ordination of unscheduled care in the Belfast Health and Social Care Trust, and across the wider HSC. Terms of Reference have been established for the review which is to be chaired by Dr D. Stewart, Director of Reviews and Medical Director. A team of expert reviewers is being recruited to carry out the review, which is to report by June 2014.

Work is progressing on planned reviews within the three year review programme. Three reviews are currently with the DHSSPS for consideration, in keeping with the agreed protocol: Oversight of patient finances; Theatre practice and Implementation of the regional Respiratory Service Framework. Work is being completed on the reports of the review of the NICE Guideline on Dementia Care Services; Respite Care and the GAIN Guideline on the Care of People with Learning Disability in Acute Hospitals. A background briefing document is being completed in relation to the Review of access to services for disadvantaged groups. Work is continuing to complete the programme of inspections in relation to the care of older people in adult wards.

RQIA has been carrying out a programme of meetings with relevant organisations to inform decisions as to whether specific recommendations can be signed off as completed from the 2011 Prison Review Team report. The first two recommendations which have been forwarded to RQIA for this consideration relate to Governance Arrangements and the Transfer of staff from the Northern Ireland Prison Service to South Eastern Health and Social Care Trust. RQIA inspectors have also been contributing to a programme of inspections of prisons in relation to prisoner safety.

1.4 Mental Health and Learning Disability

Patrick Convery, Head of MHLD Team, has been seconded to the DHSSPS for 6 months to work on incident reporting. Rosaline Kelly has been appointed as acting Head of Programme and Siobhan Rogan as acting interim Senior Inspector.

The Western Trust has submitted a robust action plan in response to the letter of escalation, following the inspection of Tyrone County Hospital (TCH) ECT Suite, and the administration of ECT resumed in TCH on 20th February 2014.

An inspection was carried out in Beechcroft (CAMHS) Unit on 16th February 2014. A number of issues have been raised with the Belfast Trust concerning the lack of progress in implementing RQIA recommendations, the use of restrictive practices, and the attendance of young people at weekly care plan meetings.

MHLD Team will facilitate a road show on 31 March 2014, in Antrim Civic Centre. The main focus of the event is the plan for inspections of all wards in Mental Health and Learning Disability hospitals in 2014/15. Information will be provided about the role of the MHLD team in RQIA, the outcomes of work undertaken in 2013/14, including findings from inspections of wards in Mental Health and Learning Disability hospitals, the inspection focus for 2014/15, and the relevance of Human Rights legislation. An update on the current position of the anticipated Mental Health Capacity legislation has also been included in the programme.

2. Significant Operational Issues or Risks

In Quarter 4 RQIA experienced disruption to IT systems over a number of days including, in particular, email capability. This matter resulted in a critical loss of capacity to send and receive emails which had an adverse impact on external communications. RQIA worked with a number of external parties to identify the source of the problem and to bring about full restoration of all critical IT services.

3. Resource Issues (Finance and Human Resources)

Finance

See Finance Report (Agenda item **C/02/14**).

At the Accountability Review meeting on 26 November 2013 the Director of Finance, DHSSPS confirmed that RQIA would be required to pay circa £33k of unfunded BSTP Programme costs (total £2.6m).

The Chief Executive wrote to DHSSPS on 11 February identifying the need for non-recurring funding of £64K in order for RQIA to cover the costs of unplanned reviews and achieve break-even. This figure excludes in-year costs in relation to the Unscheduled Care Review commissioned by the Minister.
DHSSPS has confirmed that these cost pressures will be met.

4. Corporate Governance Issues

Complaints

Since the last Board meeting, four new complaints have been received about RQIA. Three of these are about RQIA members of staff and the other about RQIA in general. Two of these complaints have been resolved under early local resolution and the other two complaints are currently being addressed in line with RQIA's Policy and Procedure on the Management and Handling of Complaints, September 2011.

Whistleblowing Disclosures

There have been thirteen whistleblowing disclosures since the beginning of January, which have been followed up in line with The Public Interest Disclosure (Northern Ireland) Order 1998 and relevant regulations.

- Seven disclosures were made in relation to nursing homes, raising concerns about low staffing levels, care practices, medicine and alleged abuse.
- One disclosure was made in relation to a residential care home, raising a number of various concerns.
- One disclosure was made in relation to a domiciliary care agency, raising allegations about low staffing levels.

- Four disclosures were made about HSC bodies, which have been forwarded to the relevant organisations for appropriate action.

Freedom of Information & Subject Access Requests

Since 1 January there have been twelve new Freedom of Information requests.

Of these:
- Partial exemption was applied to 3 requests
- Full exemption was applied to 3 requests
- Information was fully disclosed for 3 requests
- 3 recent requests are under consideration

1 new subject access request has been received since 1 January: no information was held for it.

Data Security Incident

An update was provided to the Audit Committee on 27 February in relation to the data security incident on 4 September 2013. The outcome of the ICO investigation was notified to us on 20 January. This investigation concluded that "*after careful consideration of the facts of this case, and based on the information you have provided, it does not seem appropriate for the Information Commissioner to take any formal regulatory action on this occasion*."

5. Communications

Since the January Board meeting print and broadcast media interest in the work of RQIA has focused on regulatory issues in relation: to safeguarding issues in residential care; enforcement action at nursing homes and private dental practices; and requirements for beauty clinics providing certain treatments to apply for registration with RQIA.

The inspection activity at the Royal Victoria Hospital Emergency Department and Acute Medical Unit, and the forthcoming review of unscheduled care generated strong interest, particularly around RQIA's appearance at the Health Committee on 12 February.

The ongoing independent inquiry into Child Sexual Exploitation in Northern Ireland and the recruitment of lay assessors also gathered interest.

During January and February 2014, www.rqia.org.uk received over 100,000 page views (hits) from some 15,000 visitors. Inspection reports and enforcement activity remain the most popular pages on the website. RQIA's inspections pages were accessed on over 33,500 occasions.

In late January 2014, RQIA began to make use of its Twitter account @RQIANews. To date RQIA's account has 89 followers, and RQIA communications staff monitor any references to our work.

In February 2014, the Communications team updated RQIA's general information leaflet, and have now published About Us, providing an overview of RQIA's activities and contact details.

GLENN HOUSTON

Chief Executive

11 March 2014

Appendix A

Enforcement Activity: Update: 9 January to 28 February 2014

1. Conditions of Registration

On 24 June 2013, conditions were placed on the registration of Maine Nursing Home: no new admissions to the home until RQIA is satisfied that there are robust governance and management arrangements of the home in place, and compliance with regulations and minimum standards; the nurse manager's hours will be supernumerary and dedicated to undertaking management/supervisory duties; regulation 29 and other monitoring reports provided to RQIA within three working days of completion.

Following an inspection on 9 December 2013 the condition relating to new admissions was removed. Two conditions of registration remain in place.

2. Previous Enforcement Action

Compliance with regulations was achieved at Miss Frances McCann Dental Surgery in relation to arrangements relating to the cleaning, disinfection, inspection, packaging, sterilisation, transportation and storage of reusable medical devices.

3. Ongoing Enforcement Activity: Adult Services

There is currently ongoing enforcement with respect to eight adult care services, five private dental practices and three nursing homes (see details below):

Enforcement Activity: Adult Services, as at 27 February 2014

1. Crumlin Road Dental Surgery, Belfast (R McMitchell Dental World Ltd) FTC/IHC-DT/11474/2013-14/01 FTC/IHC-DT/11474/2013-14/01(E)	17 December 2013 Compliance required by 18 February 2014 18 February 2014 Notice extended: Compliance required by 20 March 2014	1 x FTC	(01) Where reusable medical devices are used in an establishment or agency, the registered person shall ensure that appropriate procedures are implemented in relation to cleaning, disinfection, inspection, packaging, sterilisation, transportation and storage of such devices. (Reg 15 (3))

2. Lisburn Dental Surgery, Lisburn (R McMitchell Dental World Ltd) FTC/IHC-DT/11475/2013-14/01	6 January 2014 Compliance required by 10 March 2014	1 x FTC	(01) Where reusable medical devices are used in an establishment or agency, the registered person shall ensure that appropriate procedures are implemented in relation to cleaning, disinfection, inspection, packaging, sterilisation, transportation and storage of such devices. (Reg 15 (3))
3. Chester Nursing Home, Whitehead (Chester Homes Ltd) NOP/NH/1425/2013-2014/01 NOD/NH/1425/2013-2014/01	10 January 2014 Notice of Proposal to place conditions of registration Period for making representation expires on 7 February 2014 12 February 2014 Notice of decision to place conditions of registration Period to appeal to Care Tribunal expires on 15 March 2014	1 x NOP 1 x NOD	(1) The hours worked in the home by the nurse manager will be supernumerary and dedicated to undertaking management/supervisory duties. (2). The registered provider must ensure that reg 29 monthly reports and copies of any other monitoring reports are provided to RQIA within three working days of the visits/reports having been completed. The condition will continue until such times that RQIA is satisfied that the home is operating in sustained compliance with the Nursing Homes Regulations (NI) 2005 and the DHSSPS Nursing Homes Minimum Standards 2008.
4. Maguire McCann Dental Surgeons, Enniskillen (Mr J McCann) FTC/IHC-DT/11521/2013-14/01	21 January 2014 Compliance required by 24 March 2014	1 x FTC	(01) Where reusable medical devices are used in an establishment or agency, the registered person shall ensure that appropriate procedures are implemented in relation to cleaning, disinfection, inspection, packaging, sterilisation, transportation and storage of such devices. (Reg 15 (3))

5. Donaghadee Dental Surgery, Donaghadee (R McMitchell Dental World Ltd) NOP/IHC-DT/11482/2013-14/01	23 January 2014 NOP to refuse an application for registration Period for making representation expires on 22 February 2014	1 x NOP	(01) An applicant shall give (a) prescribed information about prescribed matters; (b) any other information which RQIA reasonably requires the applicant to give (Article 13(2)). If RQIA is satisfied that (a) the requirements of the regulations under Article 23; (b) the requirements of any other statutory provision which appears to RQIA to be relevant, are being and will continue to be complied with (so far as applicable) in relation to the establishment or agency, it shall grant the application; otherwise it shall refuse it (Article 14(2)). Regulations may (c) make provision as to the fitness of premises to be used as an establishment for the purposes of an agency (Article 23(2)).
6. Three Rivers Care Centre, Nursing Home, Omagh (Zest Care Homes Ltd) FTC/NH/11078/2013-14/01	4 February 2014 Compliance required by 31 March 2014	1 x FTC	(01) make suitable arrangements for the ordering, storage, stock control, recording, handling, safe keeping, safe administration and disposal of medicines used in or for the purposes of the nursing home to ensure that – (b) medicine which is prescribed is administered as prescribed to the patient for whom it is prescribed, and to no other patient; and(c) a written record is kept of the administration of any medicine to a patient. (Reg 13(4)(b)(c))
7. Loy Dental Care, Cookstown (Paul Warwick) FTC/IHC-DT/11572/2013-14/01	25 February 2014 Compliance required by 29 April 2014	1 x FTC	(01) Where reusable medical devices are used in an establishment or agency, the registered person shall ensure that appropriate procedures are implemented in relation to cleaning, disinfection, inspection, packaging, sterilisation, transportation and storage of such devices. (Reg 15 (3))

8. Faith House Nursing Home, Belfast (Faith House Board of Trustees) FTC/NH/1603/2013-14/01	25 February 2014 Compliance required by 28 April 2014	1 x FTC	(01) make suitable arrangements for the ordering, storage, stock control, recording, handling, safe keeping, safe administration and disposal of medicines used in or for the purposes of the nursing home to ensure that – (b) medicine which is prescribed is administered as prescribed to the patient for whom it is prescribed, and to no other patient; and (c) a written record is kept of the administration of any medicine to a patient. (Reg 13(4)(b)(c))

4. Enforcement Activity: Children's Services

During December 2013, notices of failure to comply with regulations were issued to a children's respite services, in relation to a breach of its statement of purpose. The service, in Omagh, achieved compliance by 17 January 2014.

The Regulation and Quality Improvement Authority

RQIA Board Meeting

Date of Meeting	11 March 2014
Title of Paper	Summary Finance Report
Agenda Item	7
Reference	C/02/14
Author	Jonathan King
Presented by	Maurice Atkinson
Purpose	The purpose of this paper is to present RQIA's summary financial position as at 31 January 2014.
Executive Summary	Breakeven
FOI Exemptions Applied	None
Equality Impact Assessment	Not applicable
Recommendation/ Resolution	The Board is asked to **NOTE** this update.
Next steps	N/A

FINANCE REPORT

Funding / Revenue Resource Limit (RRL)

RQIA's RRL remains as previously reported at £6,620,671 and includes a 1% in year non-recurrent budget retraction (£66K).

Revenue Position

RQIA's expenditure up to and including January equalled £6.11 million compared to a straight line budget of £6.23 million creating a year to date under spend of £126K. The majority of the year to date under spend is generated through the timing of non-pay expenditure including the outstanding payment for unanticipated BSTP maintenance costs.

RQIA predicts an outturn expenditure of £7.55 million equating to a £24K over spend at current allocated funding levels.

This outturn figure includes the realised and anticipated costs associated with Department/Minister commissioned reviews (CSE £51K and Cherry Tree £26K). The costs in relation to the unscheduled care review are excluded as they have not been quantified yet, and it is anticipated that any costs in 2013/14 will be relatively small.

Recent correspondence from the Department confirms funding will be made available as required in 2013/14 in relation to the commissioned reviews, thereby enabling RQIA to report a forecast **breakeven** position at year end.

Capital Resource Limit (CRL)

Due to slippage in the I-Connect project (formerly known as RISCP) it is anticipated that RQIA will hand back £79K in 2013/14. The Department has provisionally agreed that this funding will be made available in 2014/15 to complete the project.

The HSCB provided a capital allocation in October 2013 for £34K in relation to several ICT items, the largest part relating to the replacement of Tape Drives. The majority of this money was spend in January (£20K) with the balance is on schedule to be utilised before the end of March.

RQIA made a successful bid under the PC Refreshment scheme round 6 receiving £38,400. The associated computers are due to be held in a bonded warehouse with the appropriate number earmarked for RQIA by the 31st of March. These will be rolled out in 2014/15. A formal allocation letter will follow.

On invitation from the HSCB RQIA made a further capital bid for a list of ICT items and initiatives. RQIA subsequently received an email notification of an indicative allocation pending formal allocation. The ICT team is on schedule to utilise £42K of this allocation by year end.

Prompt Payment Compliance

The prompt payment target requires the payment of 95% of invoices within 30 days of receipt of goods or invoice, whichever comes later. A second target was agreed with the Department to pay 50% of invoices within 10 days.

From April to January BSO paid 1056 invoices on RQIA's behalf, of which 80.2% were processed within the departmental 30 day target. The following table shows our 30 day performance from up to and including January 2014.

Table 1: Payment Performance Vs. the 30 Day Target - 2013/14

Month	Invoices Paid			% Paid Promptly
	Total	< 30 Days	> 30 days	
Q1	397	229	168	57.7%
Q2	271	251	20	92.6%
Q3	279	261	18	93.5%
Jan	109	106	3	97.2%
Total	1056	847	209	80.2%

The cumulative 30 day performance has improved month on month, however the markedly poor performance in Q1 will prevent RQIA from achieving the cumulative 95% target in 2013/14.

Using a straight line method we could estimate the year end position as 83%. However, the associated staff disruption of February's move of the BSO payments team to the new shared service centre in Ballymena and sustained IT difficulties at the end of February in relation to the FPL systems is likely to have a detrimental effect on payment performance in February and March.

The previous finance report explained the performance up to and including November. The table below analyses the payments in December and January that failed to meet the 30 day target:

Table 2: Analysis of Invoices Paid outside 30 Days

Month	Total	31 - 45 Days	46 - 60 Days	61 - 75 Days	76 + Days
Dec	1	0	1	0	0
Jan	3	2	0	1	0
Total	4	2	1	1	0

The January outlying invoice was 68 days old and was delayed due to RQIA manager error. Training has been given to the manager involved.

The 10 day statistic also shows a general trend improvement rising steadily from 41% in April to a peak of 88% in December before dipping slightly to 79% in January. This statistic can be used as a proxy to show that that those

invoices being paid within the 30 day target are also generally being paid faster.

Of the 1056 invoices paid by BSO over April to January 60.8% were paid within 10 days. The following table shows performance from April to January against the 10 day target.

Table 3: Payment Performance Vs. a 10 Day Target - 2013/14

Month	Invoices Paid			% Paid Promptly
	Total	<10 Days	> 10 days	
Q1	397	160	403	40.3%
Q2	271	182	89	67.2%
Q3	279	214	65	76.7%
Jan	109	86	23	78.9%
Total	1056	642	580	60.8%

Outstanding Annual Fees (Debtors)

At the end of February £4K remained outstanding (0.52%) relating to 8 establishments. It is anticipated that all of this debt is recoverable and legal notices will be issued to these debtors in March.

Additionally, as the payment of Annual Fees is a condition of registration the Regulation Directorate is dealing with these establishments through our stepped approach in our enforcement policy and procedure.

All outstanding debt from pervious financial years has been recovered.

Recommendation

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

Maurice Atkinson
Director of Corporate Services

The Regulation and Quality Improvement Authority

RQIA Board Meeting

Date of Meeting	11 March 2014
Title of Paper	Corporate Performance Report
Agenda Item	8
Reference	D/02/14
Author	Stuart Crawford
Presented by	Maurice Atkinson
Purpose	The purpose of the Corporate Performance Report is to provide evidence to the Board on how well RQIA is delivering the actions identified within the annual Business Plan linked to its strategic objectives and priorities as described in the Corporate Strategy 2012-2015. The report will present a **cumulative** picture of corporate performance and summarise key achievements and issues across the financial year.
Executive Summary	At the end of the third quarter of 2013/14, 30% of the actions within the Corporate Performance Report were implemented and 64% of actions are on target for completion.
FOI Exemptions Applied	Non-confidential
Equality Impact Assessment	Not applicable
Recommendation/ Resolution	The Board is asked to **NOTE** the Corporate Performance Report.
Next steps	The report for the fourth quarter of 2013/14 will be presented to the Board on 8 May 2014.

CORPORATE PERFORMANCE REPORT 2013/14

PERIOD ENDING DECEMBER 2013

Board Meeting – March 2014

Contents

1. Introduction

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 linked to its strategic objectives and priorities as described in the Corporate Strategy 2012-2015.

RQIA's Strategic Map available on page 48 is a visual representation on one page creating an integrated and coherent picture of the organisation's forward strategy.

The report will present a **cumulative** picture of corporate performance and summarise key achievements and issues across the financial year.

Traffic Light* (Red-Amber-Green-Blue) *Rating System

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

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.

= action forecast to be completed by the completion date.

= action completed.

Exception Reporting

Exception reporting will occur as noted above. It should be succinct and structured in terms of providing a reason for the exception, identifying actions to address the situation and highlighting any emerging organisational risk as a consequence of the exception. In addition it should make clear if the Action has been cancelled or if the timeline has been extended.

Measures of Success

Information on Supporting Measures of Success is provided in the report. Measures of Success are qualitative and quantitative data that helps the organisation to gain insights, make better-informed decisions and improve performance.

Summary of Progress to Date

The report also includes a high level summary of progress made to date and an analysis of the BRAG ratings for actions at the end of the reporting period.

Frequency of Reporting

The report will be produced on a quarterly basis for consideration by the Board.

2. Summary of Traffic Light Rating System (Period Ending 31 December 2013)

The table below shows a summary of the Traffic Light rating assigned to 112 Actions within the Business Plan for the period ending 31 December 2013.

Traffic light		Period Ending June 2013	Period Ending Sept 2013	Period Ending Dec 2013	Period Ending March 2014
Red		4 (4%)	3 (3%)	5 (5%)	
Amber		0	1 (1%)	1 (1%)	
Green		100 (89%)	79 (71%)	72 (64%)	
Blue		8 (7%)	29 (25%)	34 (30%)	

At the end of the 3rd quarter of 2013/14, 94% of the actions within the Business Plan were reported as either Green or Blue.

3. Headline Achievements (Period Ending 31 Dec 2013)

3.1 Regulation - Registering *and inspecting a range of independent and statutory health and social care services*

Inspection Activity

Inspection activity at the end of Q3 is currently on target to achieve the statutory minimum number of inspections by year end. A number of services have received additional inspections to respond to identified concerns.

Within the third quarter, formal enforcement notices have been issued to the following establishments and agencies:

- Notice of decision to cancel registration was taken following consideration of representation by RQIA panel.
- Failure to comply with regulations. Eight notices issued to four Domiciliary Care Agencies and One Nursing Home.

During Q3, Regulation Directorate facilitated a series of inspector training modules on areas such as: deaf awareness; safeguarding vulnerable adults; fraud awareness; finance issues; report writing and National Preventative Mechanism. A training day was also provided for registration and administration staff and included the implementation of the new enforcement policy and procedures.

A number of opportunities to promote awareness and the work of RQIA took place in Q3. The Guidelines for Palliative and End of Life Care in Nursing and Residential Care Homes that were developed in partnership with Northern Ireland Hospice and facilitated by RQIA following a bid for funding to the Guidelines and Audit Network were launched at a regional event.

The Director of Regulation and Nursing attended a meeting of a representative forum of senior citizen groups from Belfast and Castlereagh to provide them with information on RQIA registration and inspection duties. RQIA were also represented at the National Association for Safety and Health in Care Services (NASHiCS) conference, held in Belfast during Q3.

3.2 Review - Assuring the quality of health and social care through a programme of reviews and hygiene inspections

In Q1, RQIA published its Independent Review of the Management of Controlled Drug Use in Trust Hospitals. The review found robust systems in place and made 15 recommendations to improve further what is already a comprehensive system.

In Q2 RQIA published its Baseline Review of the Implementation Process of national Institute for Health and care Excellence (NICE) Guidance in Health and Social Care (HSC) Organisations. The

review made 12 recommendations to strengthen and improve the arrangements for dissemination and implementation of NICE guidance in the HSC.

In Q2 RQIA published its Independent Review of Hospitals at Night and Weekends. This examined arrangements for management of acute medical and surgical patients across NI. The report made 29 recommendations to contribute positively to the delivery of safer care at all acute hospitals.

In Q2 RQIA also published two reports for a Baseline Assessment and Review of Learning Disability Community Services. The reports, on Children and Adults made several recommendations for improvement throughout the services.

During Q2 RQIA continued to progress a programme of infection prevention and control inspections of augmented care settings using the new standards and audit tools endorsed by DHSSPS. The initial set of inspections focused on neonatal units.

In Q3 RQIA published an Independent Review of Specialist Sexual Health Services in Northern Ireland. The review made 16 recommendations for improvement. These included: the need for clear strategic direction for sexual health services, agreed standards for service delivery, and an integrated commissioning plan for genitourinary medicine (GUM) and sexually and reproductive health (formerly known as family planning) services; the need for a workforce plan, consultant and nurse leadership, and associated training to meet future service demands; and standardisation/review of processes for booking appointments and receiving test results.

In Q3 RQIA also published an Independent Review of Statutory Fostering Services in Northern Ireland. This review team made 46 recommendations for improvement, including a call for agreed regional standards for fostering services in Northern Ireland.

During Q3, a further two reviews were commissioned by the Minister, namely:

- The Independent Expert-led Inquiry into Child Sexual Exploitation (CSE) in Northern Ireland
- The Independent Review of the Implementation of the Dental Hospital Inquiry Action Plan.

In Q3, the first wave of inspections was carried out as part of the RQIA Review of the experience of Older People in Acute Wards. These inspections are being carried out by a team of inspectors from both the review and regulation directorates.

During Q3, RQIA continued to complete infection prevention and control inspections of hospitals within the 2011/14 three year programme. It is planned to use the 2014 /15 year to continue to develop the augmented care programme and to review progress in areas previously inspected. This will enable the next three year programme to run in parallel with the new RQIA Three Year Review Programme for 2015/18.

3.3 Mental Health Order Oversight - Delivering a programme of scrutiny and review of services provided to people with a mental illness or a learning disability

During Q1 the MHLD team liaised closely with Care Quality Commission, Mental Welfare Commission (Scotland) and Healthcare Inspectorate Wales in respect of concerns about de facto detention of people with a learning disability or dementia in hospital wards and the community. A paper was finalised with case examples from all NPM members. A report of the findings was presented at the October 2013 NPM meeting in Edinburgh. The

recommendations of this report will be included in the UK National Preventative Mechanism Report in March 2014.

By end of Q3 57 (exceeded original target of 40 planned inspections) were undertaken using an agreed a list of safeguarding standards and the findings will be reported on the RQIA website.

In Q2 Quality Improvement Plans in relation to financial management of patient monies and belongings was received from the five Trusts. In Q3 further financial inspections of hospital wards commenced and this work will be completed by the end of Q4.

A Lean Project to standardise and streamline the processes and procedures in respect of detentions, guardianship, inspections, SAIs and patient experience reviews was completed and reported out on 27 August. In Q3 a review of the mechanisms for reviewing SAIs was completed and shared with the HSC Board. This will be finalised in Q4 for implementation in April 2014.

During Q3, the MHLD team reviewed all of the Electro-Convulsive Therapy (ECT) suites not accredited to ECTAS. (One suite in NHSCT and the SEHSCT suite are accredited with ECTAS). Five of the seven ECT suites in Northern Ireland were inspected in November/December 2013 (WHSCT x 2, BHSCT x 1, SHSCT x 1, NHSCT x 1). Inspection reports and QIPS will be issued in January 2014. Concerns in relation to service provision in one suite of the WHSCT was escalated.

Arrangements continue to be made with the five HSC trusts to disseminate a patient experience questionnaire derived from Electro-Convulsive Therapy Accreditation. The findings from April to November 2013 were reported at a Workshop for Part II Medical Practitioners in December 2013.

An audit of a random sample of 134 treatment plans was completed and shared at a workshop on 6 December. An audit of access to Psychological Therapies in relation to 40 SAIs was completed and shared at the workshop on 6 December for Part II Medical Practitioners in December 2013.

A number of Appointment Panel meetings were convened by Board Members between April and Dec 2013. Six Appointment Panel meetings have been held resulting in 22 Consultant Psychiatrists being appointed to the List of Part II Medical Practitioners. The names of those appointed through the revised Part II procedures and the dates of their appointment periods will be available on the RQIA website in Quarter 4.

A policy and procedure for the appointment, suspension or removal of Part IV Medical Practitioners was completed and approved by the RQIA Board in November 2013. Meetings were also held with a number of stakeholders including the Royal College of Psychiatrists (NI Branch) to discuss the new policy and procedures during Q3.

In collaboration with QUB a journal article to highlight the RQIA review of Guardianship across NI was produced. The British Association of Social Workers published the article in the November issue of 'Social Work Today'.

3.4 Key Enablers (4 - 9)

The Annual Report & Accounts 2012/13 was laid before the Assembly on 2 August following approval by the Board on 4 July. The Comptroller and Auditor General certified the 2012/13 financial accounts with an unqualified audit opinion.

The RRL for 2013/14 and an indicative allocation for 2014/15 were confirmed on 3 May.

RQIA's PPI Action Plan 2013/14 is being implemented and an update to the Board on PPI was provided at the Board Workshop on 10 October.

An Improvement and Efficiency Operational Plan 2013/14 was developed and approved by the Board on 4 July. This Plan includes the six organisational excellence improvement initiatives which are being taken forward following feedback from the EFQM assessment in 2012.

The implementation of the new *i*-Connect system is progressing well. It is anticipated that the core system will go-live at the beginning of July and the web portal will go-live at the beginning of September. Highlight and Project Board meetings take place on a regular basis. The continuing services of the current i-Connect Project Manager have been secured until the end of March 2014. Arrangements are being put in place for project management support from April onwards.

Following the Staff Workshop on 25 April two work streams were progressed. Firstly, an Action Plan was developed in relation to three key "People Issues" and this was shared with staff on 3 July. Secondly, a Culture Charter was developed and launched at staff events on 10 October and 11 November. A baseline culture survey (staff self-reflection in relation to agreed behaviours and values as set out in the Culture Charter) also took place on 10 October.

The RQIA Human Resources & Organisational Development Strategy was approved by the Board on 4 July. IiP was progressed through the completion of engagement sessions in each Directorate. Corporate and Directorate-specific IiP Actions Plans have been developed. It was agreed that we will apply for formal IiP assessment in June 2014.

An in-house management development programme ("The Developing Manager") was successfully delivered for Bands 4 and 5 via the HSC Leadership Centre.

RQIA's Risk Management Strategy was updated and approved by the Audit Committee on behalf of the Board on 21 June.

The Staff Survey (2012) was shared with staff and the Board. Feedback from staff is being addressed via the implementation of the Actions identified in RQIA's Human Resources & Organisational Development Strategy 2013-15, the Investors in People programme and the two work streams noted above linked to the Staff Workshop on 25 April. A complementary Staff Pulse Survey was undertaken in December.

RQIA's Performance Management Framework was updated and approved by the Board on 4 July.

A new Board self-assessment was completed and submitted to the Department on 1 May.

A two day workshop to review RQIA's current suite of Measures of Success took place in September and was facilitated by Pietro Micheli, Associate Professor of Organisational Performance, Warwick Business School. The outputs from the workshop were shared with the Board in December and a new suite of Measures of Success have been incorporated into the 2014/15 Business Plan.

RQIA's Annual Progress Report 2012/13 on Section 75 of NI Act 1998 and Section 49A of the Disability Discrimination Order (DDO) 2006 was approved by the Board on 3 September and submitted to EQNI.

The draft Business Plan 2014/15 was developed in consultation with staff for approval by the Board in January 2014.

4. PERFORMANCE & EXCEPTION REPORT

Summary of Actions from RQIA's Corporate Performance Report 2013/14 that require Exception Reports

Actions		Progress	Exception Report: Reason/Action/Emerging Risk	Page Number
1.2.6	Complete an evaluation of the introduction of dental regulation by RQIA. **(Sept 2013)**		The remaining dental practices are currently undergoing registration. A short life working group has been established and this action has been carried forward to 2014/15 business plan.	15
4.2.2	Implement the objectives for the year 2013/14 as set out in the Communications strategy: • Prepare a business case for replacement/ upgrade of RQIA's website. The business case will be submitted in quarter 4 2013/14, setting a realistic timescale for the work to be completed during the 2014/15 year **(STEP) (Dec 2013)**		The business case was drafted by 31 December 2013. However, additional information is required to complete the business case for submission to DHSSPS which will be submitted by the end of Q4.	28
5.2.4	Achieve at least the core Investors in People Standard **(STEP) (Dec 2013)**		Following completion of mock IiP assessments in each Directorate, the Executive Management Team has decided to apply for formal IiP accreditation in June 2014.	32
6.2.2	Transfer our income processing from SAGE to eFinancials **(May 2013)**		RQIA made a decision to use SAGE for an additional year to process and manage trade receivables because of risks with the new finance system. This will be reviewed again prior to 31st March 2014, but is likely this action will remain red at the year end.	35
8.1.1	Implement the year 2 actions from the Information and ICT Strategy. Key priorities include: • Implement i-Connect (previously known as CIMS) **(STEP)**		The revised dates for implementation of i-Connect are 30 June 2014 (Core System) and end August (Web Portal).	39
8.2.1	Implement the year 2 actions from the Information and ICT Strategy. Key		It was decided that the timing of the assessment should be moved to March 2014 to allow the implementation of the ICT	40

Actions		Progress	Exception Report: Reason/Action/Emerging Risk	Page Number
	priorities include: • Complete an assessment of RQIA's Information and ICT capability using the NHS Informatics Capability Maturity Model (ICMM) **(June 2013)**		Tech Refresh Project. It is anticipated that this action will be achieved by year end.	

Summary of Measures of Success from RQIA's Corporate Performance Report 2013/14 that require Exception Reports

<table>
<tr><th colspan="2">Supporting Measures of Success</th><th>Exception Report:
Reason/Action/Emerging Risk</th><th>Page</th></tr>
<tr><td>1.2</td><td>100% of inspection reports to be completed within 28 days from when the inspection was completed (Q)</td><td>Q2 – 73%

An increase in individual inspectors involvement in vulnerable adults investigations / strategy meetings / follow up of concerns and preparation for enforcement has impacted on our achievement of this target.</td><td>14</td></tr>
<tr><td>5.1</td><td>90% of relevant staff attend policy training/workshop events (S)</td><td>Q2 - 50% line managers / 20% staff

These figures are based on sickness training that was delivered throughout Q1 and Q2. Further training will be delivered in Q4 and reminders will continue to be sent out.</td><td>30</td></tr>
<tr><td>5.1</td><td>A minimum of 95% of all staff with completed appraisal and PDP created in Q1 (A) (DR)</td><td>A minimum of 95% of all staff with completed appraisal and PDP created in Q1 (A) (DR)

By Q1 31% of staff had completed their appraisals.
Figures received from line managers show that by the end of Q3 89% of available staff (excludes staff off on long term sick leave and maternity leave) staff had completed their appraisals. 100% of available staff will be achieved by year end.</td><td>30</td></tr>
<tr><td>5.1</td><td>100% of mandatory training completed by available RQIA staff (S)</td><td><table><tr><th colspan="2">As at 28 February 2014</th></tr><tr><td>Fire</td><td>98.74%</td></tr><tr><td>Risk</td><td>95.60%</td></tr><tr><td>Data Protection Act</td><td>97.48%</td></tr><tr><td>Freedom of Information</td><td>95.6%</td></tr><tr><td>ICT Security</td><td>96.23%</td></tr><tr><td>Records Management</td><td>94.34%</td></tr></table></td><td>31</td></tr>
</table>

<table>
<tr><td></td><td></td><td>Since all the training was rolled out, all staff have received reminders, to complete the training. RQIA will send out further reminders to all staff who have not completed the training that they must do so and a deadline has been as 31 March 2014.</td><td></td></tr>
<tr><td>6.2</td><td>95% of invoices paid each month within Terms and Conditions (30 days) (Q) (DR)</td><td><table><tr><td>Q1</td><td>58%</td></tr><tr><td>Q2</td><td>93%</td></tr><tr><td>Q3</td><td>95%</td></tr><tr><td>Q4</td><td></td></tr></table>
The accumulative figure for Q3 is currently 80.5%.

The implementation of the FPL system in 2012/13, as part of the Business Services Transformation project, created a backlog of invoices. This was due to a combination of poor user training arrangements, processing problems at the BSO scanning centre, and system functionality issues. A substantial part of the backlog was cleared in April and May of 2013 thereby significantly depressing RQIA’s payment performance in Q1 of 2013/14.</td><td>35</td></tr>
</table>

1 - Regulation - Registering and inspecting a range of independent and statutory health and social care services

1.1 - Completed an annual targeted and proportionate regulation programme to protect and safeguard the public and achieve improved outcomes for service users

Actions		Progress	Exception Report: Reason/Action/Emerging Risk
1.1.1	Review all registration procedures developed as a result of LEAN methodologies to inform RISCP development **(STEP)**[1] **(Sept 2013)**		
1.1.2	Complete and implement all inspection procedures developed as a result of LEAN methodologies **(STEP)** **(March 2014)**		
1.1.3	Complete a programme of themed and focused inspections to all regulated sector services in line with identified health and social care risk factors and the statutory		

Supporting Measures of Success

Q = to be reported on quarterly basis
S = to reported on six monthly basis
A = to be reported annually

Number of variations made during the previous quarter to the register of all establishments and agencies as defined in the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 (Q)

Service Category	New Registrations				De-Registrations			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Adult Placement Agencies								
Children's homes			1		2			
Day Care Settings	4	1			2	1		
Domiciliary Care Agencies	2	4			3		3	
Domiciliary Care Agencies -SL	10	3	1			4	2	
Independent clinics	3	1	2				1	
Independent hospitals			1					
Independent hospitals - dental treatment	11	9	6			3		
Independent medical agencies		1	3					
Nursing agencies		2			2			
Nursing homes	1		1		1			
Residential care homes					2	7	1	
Residential Family Centres								
Voluntary Adoption Agencies								
Total	**31**	**21**	**15**		**12**	**15**	**7**	

[1] Improvement action incorporated in RQIA's Steps to Excellence Programme (STEP)

Actions		Progress	Exception Report: Reason/Action/Emerging Risk
	minimum frequencies outlined within the HPSS Fees and Frequencies Regulations (NI) 2005/2007 using RQIA's Inspection Planning Approach **(DR)** [2] **(March 2014)**		
1.1.4	Complete a programme of inspections above those set out in the HPSS Fees and Frequencies Regulations (NI) 2005/2007, where assessed as necessary to provide assurance on the quality and safety of regulated services **(March 2014)**		
1.1.5	Complete implementation plan to support delivery of RQIA's NPM responsibilities in regulated services		

Supporting Measures of Success

Q = to be reported on quarterly basis
S = to reported on six monthly basis
A = to be reported annually

100% of inspections completed in line with the statutory minimum requirements (measured against valid number of establishments)(Q)

% of services that have received minimum inspections					No of services (minus non active services)		Total no of Inspections in registered services
Category	**Q1**	**Q2**	**Q3**	**Q4**	**Registered**	**Received stat min**	
Adult Placement Agencies	0%	100%	100%		4	4	4
Children's homes*	6%	33%	65%		49	32	96
Day Care Settings	30%	54%	81%		188	152	212
Domiciliary Care Agencies	27%	59%	87%		108	94	102
Domiciliary Care Agencies - SL	29%	53%	78%		178	138	170
Independent clinics	19%	39%	91%		34	31	43
Independent hospitals	8%	25%	77%		13	10	16
Independent hospitals - dental treatment	30%	59%	86%		369	319	361
Independent Medical Agencies	0%	50%	80%		5	4	4
Nursing agencies	17%	16%	16%		25	4	5
Nursing homes*	14%	40%	69%		267	185	552
Residential care homes*	9%	35%	66%		205	135	396
Residential Family Centres	0%	0%	0%		2	0	0
Voluntary Adoption Agencies	0%	0%	0%		4	0	0
Overall Total	**22%**	**48%**	**76%**		**1451**	**1108**	**1961**

***** Require minimum of two inspections

[2] Action meets the criteria set out in the DHSSPS Business Planning Departmental Requirements 2013-14

Actions		Progress	Exception Report: Reason/Action/Emerging Risk	Supporting Measures of Success *Q = to be reported on quarterly basis* *S = to reported on six monthly basis* *A = to be reported annually*
	(March 2014)			***75% of all incidents to be acknowledged and initially processed by inspection staff within seven days (Q)*** **Q1** 68% **Q2** 70% **Q3** 66% **Q4** ***100% of services inspected, during inspection year, will have a validation checklist completed (by 31 March 2014)(Q)*** **Q1** 74% **Q2** 71% **Q3** 70% **Q4** ***75% of registration of managers to be processed in line with the registration procedures and timescales (Q)*** **Q1** 83% **Q2** 76% **Q3** **74%** **Q4** ***Demonstrate improvements in safety and quality of services through an assessment of the level of compliance with regulations and standards (A)***
1.1.6	Applying RISCP systems across the regulation directorate **(March 2014)**			

1.2 - Ensured that regulation is carried out effectively and that its outcomes and impact on policy are communicated to all relevant stakeholders

	Actions	Progress	Exception Report: Reason/Action/Emerging Risk
1.2.1	Provide open inspection reports on all regulated sector service inspections on line within pre-set reporting targets (this does not include children's services) **(March 2014)**		
1.2.2	Publish an annual regulation report for the year 2012/13 **(Dec 2014)**		
1.2.3	Ensure that relevant issues and recommendations relating to policy and standards are notified for action to DHSSPS, PHA, HSC Board and HSC Trusts **(DR) (March 2014)**		
1.2.4	Provide advice to the Department through participation at the minimum standards working groups and any other matter connected to the provision of services **(DR) (March 2014)**		
1.2.5	Gather intelligence from service providers through regulation activity, forums and a range of liaison meetings **(March 2014)**		

Supporting Measures of Success

Q = to be reported on quarterly basis
S = to reported on six monthly basis
A = to be reported annually

100% of inspection reports to be completed within 28 days from when the inspection was completed (Q)

Draft reports are to be produced and sent back to the provider within 28 days of the inspection taken place.

	Draft Reports
Q1	69%
Q2	73%
Q3	73%
Q4	

Demonstrate evidence of stakeholder engagement through an evaluation of the attendees at provider events (A)

Actions		Progress	Exception Report: Reason/Action/Emerging Risk	Supporting Measures of Success *Q = to be reported on quarterly basis* *S = to reported on six monthly basis* *A = to be reported annually*
1.2.6	Complete an evaluation of the introduction of dental regulation by RQIA. **(Sept 2013)**		The remaining dental practices are currently undergoing registration. A short life working group has been established and this action has been carried forward to 2014/15 business plan.	

2 - Review - Assuring the quality of health and social care through a programme of reviews and hygiene inspections

2.1 - Provided public assurance that agreed quality standards for health and social care are being achieved

	Actions	Progress	Exception Report: Reason/Action/Emerging Risk
2.1.1	Conduct a review programme examining and reporting on the quality and availability of health and social care services, including clinical and social care governance reviews within the HSC by means of thematic and special reviews and making recommendations for improvement **(DR)** **(April 2015)**		
2.1.2	Provide the Department with advice, reports or information in relation to the provision of service or the exercise of its functions, at the Department's request **(DR)** **(March 2014 / On-going)**		
2.1.3	Report on the reviews in the Three Year Review Programme in order to keep the Department informed about the provision of services and in particular their availability and quality **(DR)** **(March 2014 / On-going)**		

Supporting Measures of Success

Q = to be reported on quarterly basis
S = to reported on six monthly basis
A = to be reported annually

Complete ten reviews for the year 2013/14 (Q)

Reviews	B/F from 2012/2013 Year Q3	2013/2014 Year Q3
Newly Commissioned	0	2
To Commence	0	3
In Progress	0	5
Reporting	2	5
Published	2	0
Published (Cumulative Total for Year)	6	0

**Care of Older People moved to 2013/2014 year

Number of reviews completed as set out in the Three-Year Review Programme 2012/15 (S)

Review Programme 2012-2015	Year One 2012 / 2013	Year Two 2013 / 2014	Year Three 2014 / 2015
Total Reviews in Programme	10**	12	11
Fieldwork Completed	10	5	0

***Care of Older People Review moved to Year Two 2013/2014*

Actions		Progress	Exception Report: Reason/Action/Emerging Risk
2.1.4	Develop a delivery plan for achieving the 2013/14 year of scheduled thematic reviews **(April 2013)**		
2.1.5	Complete the reviews as set out in the 2013/14 delivery plan **(March 2014)**		
2.1.6	Develop a delivery plan for achieving the programme of infection prevention/hygiene inspections for 2013/14 **(April 2013)**		
2.1.7	Complete a programme of infection prevention/hygiene inspections for 2013/14 **(DR) (March 2014)**		
2.1.8	Develop a delivery plan for achieving the programme of inspections in augmented care settings **(April 2013)**		
2.1.9	Complete the augmented care settings inspections as set out in the delivery plan for 2013-14 **(March 2014)**		
2.1.10	Complete a programme of IR(ME)R inspections with input from the Health Protection Agency (HPA) **(DR) (March 2014)**		

Supporting Measures of Success *Q = to be reported on quarterly basis* *S = to reported on six monthly basis* *A = to be reported annually*
Complete 100% of announced and unannounced infection prevention/hygiene inspections as set out in the planned programme for 2011/14 (Q)
The Infection Prevention Hygiene Team (IPHT) are in the final year of a three year programme of inspection which commenced in 2011.
During Q1 a programme of infection prevention/hygiene inspections was developed and is on schedule for completion.
During Q1 additional inspection activity was undertaken as part of the first year programme of augmented care inspections to HSC Neonatal and SCBU Units. Completed
Planning and development of inspection methodology commenced for the Review of the care of older people in acute hospitals To commence in Q3
Planning and development and some fieldwork commenced for the joint review of Prisoner Safety with CJINI
Work was undertaken with the development of the Prison Review Team(PRT) recommendations
Lay Assessors documentation was devised and sent out for comments

Actions		Progress	Exception Report: Reason/Action/Emerging Risk
2.1.11	Undertake healthcare inspections to prison and other criminal justice settings, in collaboration with other regulators **(March 2014)**		
2.1.12	Report on the findings in relation to joint inspections of prison health care in collaboration with other regulators **(DR) (March 2014)**		
2.1.13	Undertake thematic reviews as required in prison healthcare and report on findings **(March 2014)**		
2.1.14	Undertake the work required to provide an overview on the progress made in relation to the healthcare recommendations within the report of "Review of the NI Prison Service" (PRT Prison Review Team Final Report October 2011) **(DR) (March 2014)**		

Supporting Measures of Success

Q = to be reported on quarterly basis
S = to reported on six monthly basis
A = to be reported annually

Completion of an annual overview report of the outcomes of the infection prevention/hygiene inspections (A)

Complete the annual IR(ME)R activity as set out in the planned programme (S)

	Number Planned	Number Completed
Q1	1	1
Q2	2	1
Q3	3	3
Total	**6**	**5**

2.2 - Ensured that all review activity is designed to support continuous improvement and protect rights

	Actions	Progress	Exception Report: Reason/Action/Emerging Risk
2.2.1	Assess during the planning and evaluation stages the impact of individual reviews on improving services and protecting rights **(March 2014)**		
2.2.1	Establish a process whereby it can be demonstrated that recommendations from 2012/2013 review reports have been taken forward **(STEP) (March 2014)**		
2.2.3	Contribute to the work of the Regional Group set up to publish the first Annual Quality Report by 31 March 2014 **(DR) (March 2014)**		

Supporting Measures of Success *Q = to be reported on quarterly basis* *S = to reported on six monthly basis* *A = to be reported annually*
Report on progress made on taking forward the recommendations from reviews which were published in 2012/13 (A)

2.3 - Informed the development of regional policy, standards and guidance

	Actions	Progress	Exception Report: Reason/Action/Emerging Risk
2.3.1	Ensure there is effective liaison with Regional Policy Leads during the planning and delivery of reviews **(March 2014)**		
2.3.2	Set each review in the context of relevant regional policy, standards and guidance and, where appropriate, make recommendations regarding the need for development and improvement **(March 2014)**		

Supporting Measures of Success *Q = to be reported on quarterly basis* *S = to reported on six monthly basis* *A = to be reported annually*
Documented evidence of RQIA's contribution to policy, standards and guidance on health and social care locally and nationally in relation to service delivery and practice (A)

<u>3 - Mental Health Order Oversight</u> - Delivering a programme of scrutiny and review in services provided to people with a mental illness or a learning disability

3.1 - Provided optimal safeguards for all users of mental health and learning disability services

	Actions	Progress	Exception Report: Reason/Action/Emerging Risk
3.1.1	Complete a minimum of 100[3] Patient Experience Reviews under the Human Rights Theme of Protection in places of detention **(March 2014)**		
3.1.2	Complete and evaluate the Public Participation Initiative (PPI) in relation to involvement of Care Experienced Persons in MHLD inspection processes **(June 2013)**		
3.1.3	Monitor the administration of the use of Electroconvulsive Therapy (ECT) across NI and take forward the recommendations for RQIA contained in the 2012 ECT Review Report **(March 2014)**		
3.1.4	In collaboration with QUB produce a journal article to highlight the RQIA review of Guardianship across NI **(Sept 2013)**		

Supporting Measures of Success

Q = to be reported on quarterly basis
S = to reported on six monthly basis
A = to be reported annually

Number of patients interviewed during the inspection process of mental health and learning disability facilities (Q)

Q1	2 Patient Experience Interviews completed
Q2	48 Patient Experience Interviews completed
Q3	50 Patient Experience Interviews completed
Q4	

Complete minimum of 40 Inspections to MHLD facilities (A)

Q1	15 Inspections completed
Q2	21 Inspections completed
Q3	21 Inspections completed
Q4	

100% of prescribed forms of patients detained and subject to Guardianship monitored (Q)

Q1	100%
Q2	100%
Q3	100%
Q4	

[3] The number of planned Patient Experience Reviews has been reduced from 200 to 100

Actions		Progress	Exception Report: Reason/Action/Emerging Risk
3.1.5	Complete an audit of a random sample of 40 treatment plans and report on the findings to the Trusts **(Sept2013)**		
3.1.6	Complete an audit of the use of Psychological Therapies in relation to 40 SAIs reported to MHLD team **(Sept 2013)**		

Supporting Measures of Success

Q = to be reported on quarterly basis
S = to reported on six monthly basis
A = to be reported annually

100% of all detected errors contained in detention forms notified to health and social care trusts within 72 hours (Q)

Q1	100%
Q2	100%
Q3	100%
Q4	

Number of SAIs screened by mental health and learning disability team each quarter (Q)

Q1	33 SAIs screened
Q2	27 SAIs screened
Q3	50 SAIs screened
Q4	

Number of SAIs received by mental health and learning disability team in quarter (Q)

Q1	55 SAIs received
Q2	44 SAIs received
Q3	47 SAIs screened
Q4	

Evaluate and demonstrate improvements in the PPI pilot to involve Care Experienced Persons in the inspection processes (A)

Completed involving 3 experts with care experience in the inspection of 3 LD facilities. It is anticipated that this will be extended to other inspections/patient experience interviews post evaluation.

3.2 - Ensured that all review and inspection activity drives service improvement and is communicated to stakeholders

	Actions	Progress	Exception Report: Reason/Action/Emerging Risk
3.2.1	Complete and implement a full review of all MHLD inspection and patient experience interview procedures using LEAN methodology **(March 2014)**		
3.2.2	Complete a programme of planned inspections of establishments providing care and treatment to individuals with mental illness and/or learning disability **(March 2014)**		
3.2.3	Meet with Trust Senior Managers to provide feedback on the Trusts performance in the discharge of their functions under the Mental Health (NI) Order 1986 **(Dec 2013)**		
3.2.4	Take forward the recommendations from the Internal Audit Report in respect of the Discharge of Article 116 by the MHLD Programme of Care **(Sept 2013)**		
3.2.5	Complete a report on the discharge of statutory functions by the MHLD Team in relation to the Mental Health (NI) Order 1986 **(March 2014)**		

Supporting Measures of Success

Q = to be reported on quarterly basis
S = to reported on six monthly basis
A = to be reported annually

Evaluate LEAN project and demonstrate improvements in inspection and patient experience interview procedures using baseline and 'report out' measurements (A)

VSM week completed 16-8 July
Kaizen week completed 12 August 2013

100% of inspection reports completed within 28 days from the completion of the inspection (Q)

Q1	100%
Q2	100%
Q3	50%
Q4	

100% of QIPs issued to Trusts returned within 28 days (Q)

Q1	100%
Q2	100%
Q3	41%
Q4	

100% of Trusts engaged annually through a formal meeting with the MHLD directorate (A)

Initial meetings have taken place with senior staff in all five trusts.

Actions		Progress	Exception Report: Reason/Action/Emerging Risk	Supporting Measures of Success *Q = to be reported on quarterly basis* *S = to reported on six monthly basis* *A = to be reported annually*
3.2.6	Report on the full range of activities completed by the MHLD Team as a National Preventive Mechanism (NPM) in monitoring loss of liberty in places of detention, in keeping with the expectations of the UK Central Coordinating Body **(Nov 2013)**			
3.2.7	Complete a review of Risk Assessment and Risk Management in Addiction Services **(March 2014)**			

3.3 - Engaged effectively in the development of policy and emerging legislation

Actions		Progress	Exception Report: Reason/Action/Emerging Risk	Supporting Measures of Success *Q = to be reported on quarterly basis* *S = to reported on six monthly basis* *A = to be reported annually*
3.3.1	Provide on-going advice and guidance to DHSSPS on the implications of the draft Mental Capacity (Health, Welfare and Finance) Bill for RQIA and projected costings to enable new proposed functions to be undertaken. **(March 2014)**			***Documented evidence of RQIA's contribution to policy, standards and guidance on health and social care locally and nationally (A)*** ***Key issues relevant to patients will be reflected in the new mental capacity legislation (A)***

4 - Engagement & Communications - Engaging and communicating effectively with our stakeholders

4.1 - Embedded personal and public involvement (PPI) as a fundamental part of all of RQIA 's work

	Actions	Progress	Exception Report: Reason/Action/Emerging Risk	Supporting Measures of Success *Q = to be reported on quarterly basis* *S = to reported on six monthly basis* *A = to be reported annually*
4.1.1	Implement PPI Action Plan for 2013/14 inclusive of monitoring and evaluation of all PPI activity. Key activities include: • Ensure the active involvement of service user views in conventional domiciliary care agency inspection • Ensure the active involvement of service user views in MHLD • Ensure the active involvement of service user views in Regulation • Complete and evaluate a pilot programme of inspections of 10 nursing homes using peer facilitators • Contribute to the development of PPI regional standards and guidelines. • Contribute to the development of regional LGBT older people's guidelinesReview peer			***Demonstrate that a minimum of 90% of PPI actions in the Annual PPI Plan are successfully implemented on target and evidence the benefits (S)*** Q3 - 94% of actions due for completion delivered on time

Actions	Progress	Exception Report: Reason/Action/Emerging Risk	Supporting Measures of Success *Q = to be reported on quarterly basis* *S = to reported on six monthly basis* *A = to be reported annually*
reviewer's input (VOYPIC & Sixth Sense) into the inspection of children's homes for effectiveness of outcomes and to test sustainability • Introduce a lay reviewer's component into the Infection Prevention Hygiene Programme • Review lay reviewer's input into the Three Year Review Programme **(March 2014)**			

4.2 - Developed effective communication methods to meet the complex and varied needs of the Northern Ireland public

	Actions	Progress	Exception Report: Reason/Action/Emerging Risk
4.2.1	Attend and contribute to national and international learning events (5 Nations and EPSO) to ensure sharing and learning from best regulatory practice **(March 2014)**		
4.2.2	Implement the objectives for the year 2013/14 as set out in the Communications strategy: • Deliver a series of provider information road shows/meetings for all registered agencies and establishments giving feedback on inspection outcomes for the year 2013/14 and outlining inspection themes for the year 2014/15 **(Feb 2014)** • Publish overview reports to inform the public of the overall assessment of the quality and availability of services **(Jan 2014)**[4] • Identify and provide key documents in easy to read/		

Supporting Measures of Success *Q = to be reported on quarterly basis* *S = to reported on six monthly basis* *A = to be reported annually*
Demonstrate that a minimum of 90% of communications actions in the communication strategy action plan are implemented on target and evidenced (S) Q2 - All RQIA's communication activities are delivered in line with the communication strategy and associated action plan. ***Demonstrate sharing of learning with other regulators through engagement with UK public sector regulators and European health and social care regulators (S)*** During quarter 2 RQIA engaged with European health and social care regulators at the EPSO conference. This included sharing learning on a range of issues including RQIA's response to the Francis Inquiry.

[4] Date changed from Dec 2013 to Jan 2014 as the Regulation and Hygiene reports will be reported at the January Board Meeting with stats from up to the end of December 2013.

	Actions	Progress	Exception Report: Reason/Action/Emerging Risk	Supporting Measures of Success *Q = to be reported on quarterly basis* *S = to reported on six monthly basis* *A = to be reported annually*
	user friendly versions for children and adults with a learning disability **(March 2014)** • Prepare a business case for replacement/ upgrade of RQIA's website. The business case will be submitted in quarter 4 2013/14, setting a realistic timescale for the work to be completed during the 2014/15 year **(STEP) (Dec 2013)** • Explore the use of social media as a means of increasing the profile of the organisation across Northern Ireland **(STEP) (Dec 2013)**	 	The business case was drafted by 31 December 2013. However, additional information is required to complete the business case for submission to DHSSPS which will be submitted by the end of Q4.	
4.2.3	Establish a working group to agree and develop a range of methods for capturing feedback from our key stakeholders on the work of RQIA **(March 2014)**			

5: People - Developing and maintaining a competent, valued and motivated workforce Strategic Objectives

5.1 - Continued to ensure that we have a professionally competent workforce delivering on RQIA 's strategic objectives

	Actions	Progress	Exception Report: Reason/Action/Emerging Risk
5.1.1	Facilitate 8 half day Action Learning Sets sessions, during 2013/14 **(March 2014)**		
5.1.2	Development and collation of Corporate and Directorate L&D plans, linked to the business plan and common themes within PDPs **(STEP)** **(June 2013)**		
5.1.3	Develop an action plan to implement KSF by further developing outlines in conjunction with staff and their representatives, and link appraisals to outlines **(DR)** **(March 2014)**		
5.1.4	Design and delivery of a suite of HR policies and skills training **(March 2014)**		
5.1.5	Review and update as necessary HR policies in light of BSTP **(March 2014)**		
5.1.6	Production of sickness reports to EMT and the Board, and regular liaison with line		

Supporting Measures of Success

Q = to be reported on quarterly basis
S = to reported on six monthly basis
A = to be reported annually

Staff assessment of learning from RQIA Action Learning Set (A)

A minimum of 95% of all staff with completed appraisal and PDP created in Q1 (A) (DR)

By Q1 31% of staff had completed their appraisals.

% time lost due to sickness on average not in excess of 4.8% (Q) (DR)

Q1	4.1%
Q2	4.14%
Q3	3.3%
Q4	

90% of relevant staff attend policy training/workshop events (S)

Q2	50% line managers / 20% staff

Actions		Progress	Exception Report: Reason/Action/Emerging Risk
	managers regarding the management of individual cases, with a view to facilitate a return to work/ improve attendance **(DR) (March 2014)**		
5.1.7	Produce a report to the Board and Department of the key reasons behind staff absence and patterns in long term and short term absence **(DR) (Sept 2013)**		
5.1.8	In conjunction with BSO, provide a means whereby all staff and new starts are aware of and prepared for auto enrolment on pension schemes **(DR) (June 2013)**		During Q1 RQIA was advised by BSO that auto enrolment on pension schemes would be deferred to Sept 2017.
5.1.9	Implement the year 1 actions from the HR & Organisational Development Strategy **(STEP) (March 2014)**		
5.1.10	Fulfil our responsibility as a designated body as outlined in 'The Medical Profession (Responsible Officers) Regulations (Northern Ireland) 2010 **(DR) (March 2014)**		

Supporting Measures of Success

Q = to be reported on quarterly basis
S = to reported on six monthly basis
A = to be reported annually

100% of mandatory training completed by available RQIA staff (S)

As at 28 February 2014	
Fire	98.74%
Risk	95.60%
Data Protection Act	97.48%
Freedom of Information	95.6%
ICT Security	96.23%
Records Management	94.34%

5.2 - Designed and implemented a range of organisational development initiatives

	Actions	Progress	Exception Report: Reason/Action/Emerging Risk
5.2.1	In conjunction with HSC Leadership Centre, commission the design and delivery of a bespoke "menu" of skills workshops for managers **(Sept 2013)**		
5.2.2	Review and revise RQIA's Induction policy and process **(Sept 2013)**		
5.2.3	Ensure staff are trained, well informed and supported during the implementation of BSTP **(June 2013)**		
5.2.4	Achieve at least the core Investors in People Standard **(STEP) (Dec 2013)**		Following completion of mock IiP assessments in each Directorate, the Executive Management Team has decided to apply for formal IiP accreditation in June 2014
5.2.5	Produce and implement an action plan based on the results of the Regional Staff Survey **(STEP)** **(March 2014 / On-going)**		
5.2.6	Implement the year 1 actions from the HR & Organisational Development Strategy **(STEP)** **(March 2014)**		

Supporting Measures of Success *Q = to be reported on quarterly basis* *S = to reported on six monthly basis* *A = to be reported annually*
Successful implementation of BSTP, defined as all available staff trained and within 3 months of roll out staff are confident in operating ESS/MSS (A)

6 - Performance - Managing and monitoring corporate and financial performance to improve organisational effectiveness

6.1 - Embedded a fully integrated planning and performance management approach to manage the organisation more effectively and efficiently and promote continuous improvement and learning

	Actions	Progress	Exception Report: Reason/Action/Emerging Risk
6.1.1	Develop and seek Board approval of RQIA's Business Plan 2014-15 **(DR) (Jan 2014)**		
6.1.2	Initiate work to review and further develop RQIA's "Measures of Success" **(STEP) (March 2014)**		
6.1.3	Implement the Sustainability Delivery Plan which supports the PFG target to reduce greenhouse gas emissions and the DHSSPS objectives as outlined in the Sustainable Development Strategy "Everyone's Involved" and the Strategy implementation plan "focused on the future" **(DR) (STEP) (March 2014)**		
6.1.4	Produce RQIA's Property Asset Management Plan and forward to the DHSSPS(NI) for approval **(DR) (March 2014)**		
6.1.5	Produce Corporate Performance Reports quarterly and present to		

Supporting Measures of Success

Q = to be reported on quarterly basis
S = to reported on six monthly basis
A = to be reported annually

Minimum of 90% of actions identified within the annual business plan successfully implemented within timescale (Q)

Q1	7% of actions implemented
Q2	25% of actions implemented
Q3	30% of actions implemented
Q4	

100% of measures of success reported as being progressed within timescales (Q)

Q1	(98%) 1 measure not reported on time
Q2	(98%) 1 measure not reported on time
Q3	100%
Q4	

Minimum of 90% of actions successfully implemented within timescale from the sustainability development action plan (S)

Q2- 100% of actions implemented on target

Actions		Progress	Exception Report: Reason/Action/Emerging Risk
	RQIA's Board **(March 2014 / On-going)**		
6.1.6	Review and update RQIA's Performance Management Framework **(July 2013)**		
6.1.7	Identify, prioritise and implement STEP improvement actions based on the EFQM external assessment feedback report **(STEP)** **(March 2014 / On-going)**		
6.1.8	Improve the quality of business cases (revenue and capital) and post project evaluations by: • Conducting an annual review of the business planning processes **(April 2013)** • Developing a spreadsheet for all revenue and capital business cases and copy to Department; **(April 2013)** • Ensuring capital projects are submitted to the Department is in line with agreed timeframes **(March 2014)** • Ensuring that a suitable skills base is maintained / developed **(DR)** **(March 2014)**	   	

Supporting Measures of Success *Q = to be reported on quarterly basis* *S = to reported on six monthly basis* *A = to be reported annually*
Demonstrate that a minimum of 100% of STEP actions are successfully implemented on target and evidence the benefits (Q) By the end of Q3 the six STEP initiatives (100%) from within the Improvement and Efficiency Operational Plan are on target. Initiatives delivered to date include completion of LEAN project in MHLD, engagement meetings with HSC Leadership Centre to ascertain readiness for application to Investing in People external assessment, and completion of work to launch RQIA's agreed Culture Charter.

6.2 - Aligned resources to support RQIA's strategic priorities and maintained our financial performance

	Actions	Progress	Exception Report: Reason/Action/Emerging Risk
6.2.1	Secure adequate funding for the 2014/15 Business Plan and manage the balance of CSR efficiencies by implementing the Improvement and Efficiency Plan **(DR) (March 2014)**		
6.2.2	Transfer our income processing from SAGE to eFinancials **(May 2013)**		RQIA made a decision to use SAGE for an additional year to process and manage trade receivables because of risks with the new finance system. This will be reviewed again prior to 31st March 2014.
6.2.3	Produce an Annual Report (incorporating an approved set of Accounts and Statement of Internal Control approved by NIAO) **(DR) (July 2013)**		
6.2.4	Develop, implement and monitor a Capital Investment Plan **(March 2014)**		
6.2.5	Refine the Budgetary Reporting System through migration to the new suite of BSTP finance systems **(STEP) (March 2014)**		
6.2.6	Set out steps to provide assurance during 2013/14 to		

Supporting Measures of Success

Q = to be reported on quarterly basis
S = to reported on six monthly basis
A = to be reported annually

Breakeven on income and expenditure (+/- 0.25%) (Q) (DR)

Q1	On target to break even
Q2	On target to break even
Q3	On target to break even
Q4	

Attainment of CSR efficiency savings through the delivery of the Improvement and Efficiency Plan (S)

Q2 - On target

95% of invoices paid each month within Terms and Conditions (30 days) (Q) (DR)

Q1	58%
Q2	93%
Q3	95%
Q4	

100% of outstanding debt recovered within the financial year (Q)

Q3 – 97.25% of debt recovered

Actions		Progress	Exception Report: Reason/Action/Emerging Risk	Supporting Measures of Success *Q = to be reported on quarterly basis* *S = to reported on six monthly basis* *A = to be reported annually*
	your Board to demonstrate compliance with DFP and Departmental procurement requirements/guidance including: • Procurement guidance notes as set out in HSC Finance circulars, procurement Estates Letters (PELs), the Ministerially approved recommendations in the Department's Review of Procurement, and agreed recommendations of the Public Accounts Committee **(DR) (March 2014)**			
6.2.7	During 2013/14, adoption or maintenance of good procurement practice, as specified to individual ALBs in the Department's Review of Procurement, or as separately promulgated by the Department, and establish a process to provide assurance to RQIA's Board in this regard **(DR) (March 2014)**			
6.2.8	Liaise with BSO to determine a realistic 10 day prompt payment target **(DR)**			

Actions		Progress	Exception Report: Reason/Action/Emerging Risk	Supporting Measures of Success *Q = to be reported on quarterly basis* *S = to reported on six monthly basis* *A = to be reported annually*
	(March 2014)			
6.2.9	Produce year-end forecast and monthly profiled financial forecast of expenditure to DHSSPS each month in line with deadlines and that any variances +/- 5% of the previous month's forecast are fully explained **(DR) (March 2014)**			
6.2.10	Produce monthly year-end financial forecast as at September 2013 (and subsequent months) within +/- 0.5% of the final outturn **(DR) (March 2014)**			
6.2.11	Conduct a review of management costs within RQIA and prepare a report and savings plan to be approved by RQIA's Board and DHSSPS **(DR) (June 2013)**			

7 – Evidence - Underpinning our regulatory practice using research and available evidence

7.1 - Embedded an evidence and research based culture within RQIA

	Actions	Progress	Exception Report: Reason/Action/Emerging Risk	Supporting Measures of Success *Q = to be reported on quarterly basis* *S = to reported on six monthly basis* *A = to be reported annually*
7.1.1	Implement the objectives for the year 2013/14 as set out in the Evidenced Based Practice Framework and supporting Action Plan **(March 2014)**			***A minimum of 90% of actions successfully implemented within timescale from the Evidenced Based Practice Action Plan (S)*** Q3 – 100% By the end of Q3 2 actions have been implemented and from the remaining actions are on target. 4 actions have been removed from the plan as they will be taken forward by the HSC Leadership Knowledge Shop.

8 - Information - Managing information and ICT effectively

8.1 - Ensured that information is managed effectively to support RQIA's strategic and operational objectives

	Actions	Progress	Exception Report: Reason/Action/Emerging Risk	Supporting Measures of Success *Q = to be reported on quarterly basis* *S = to reported on six monthly basis* *A = to be reported annually*
8.1.1	Implement the year 2 actions from the Information and ICT Strategy. Key priorities include: • Implement i-Connect (previously known as CIMS) **(STEP)** • Complete the CAS on Information Management **(DR)** **(March 2014)**	 	The revised dates for implementation of i-Connect are 30 June 2014 (Core System) and end August (Web Portal).	***Minimum of 90% of year 2 Information and Records actions in the Information and ICT Strategy successfully implemented within timescale (S)*** Q2 – 88% completed on target (based on 1 action not implemented on target) ***Attainment of at least moderate compliance of the revised Information Management CAS (A)***

8.2 - Complied with best practice and the highest standards of information governance

	Actions	Progress	Exception Report: Reason/Action/Emerging Risk
8.2.1	Implement the year 2 actions from the Information and ICT Strategy. Key priorities include: • Review the suite of information governance policy and procedures **(March 2014)** • DPA Freedom of Information compliance (100%) **(Sept 2013)** • Complete an assessment of RQIA's Information and ICT capability using the NHS Informatics Capability Maturity Model (ICMM) **(June 2013)** • Complete database manuals for each corporate system including sections on data quality mechanisms **(March 2014)**	   	It was decided that the timing of the assessment should be moved to March 2014 to allow the implementation of the ICT Tech Refresh Project.
8.2.2	Provide a link to NINIS on RQIA's website **(March 2014)**		
8.2.3	Take steps to maintain/ improve the quality of information/data being presented to the ALB Board by: • Identifying before the end of April 2013 an Executive		

Supporting Measures of Success

Q = to be reported on quarterly basis
S = to reported on six monthly basis
A = to be reported annually

100% subject access requests completed within 40 days (Q)

Q1	2 (100%)
Q2	3 (100%)
Q3	2 (100%)
Q4	

100% of freedom of information (FOI) requests responded to within 20 working days (Q)

Q1	22 (100%)
Q2	20 (100%)
Q3	12 (100%)
Q4	

Attainment of at least level 2 capacity in the NHS Informatics Capability Maturity Model (ICMM) (A)

Actions	Progress	Exception Report: Reason/Action/Emerging Risk	Supporting Measures of Success *Q = to be reported on quarterly basis* *S = to reported on six monthly basis* *A = to be reported annually*
Board member lead with responsibility for providing assurance on the quality of data/information presented to the ALB board to support decision-making; **(DR) (April 2013)** • Taking steps to ensure that during 2013/14 a data quality assurance process is in place which provides the Board with assurance that data collected and information provided to them is fit for purpose, robust and of a consistently high standard; and, **(DR) (March 2014)** • Ensuring that the Board is provided with and considers as appropriate the publications of Northern Ireland official and national statistics on health and in particular those that inform progress against ministerial targets. **(DR) (March 2014)**	  		

8.3 - Continued to provide an ICT environment that is user focused and able to respond effectively and efficiently to RQIA 's changing business needs in order to support the organisation in meeting its statutory requirements

	Actions	Progress	Exception Report: Reason/Action/Emerging Risk
8.3.1	Implement the year 2 actions from the Information and ICT Strategy. Key priorities include: • Test the ICT Disaster Recovery Plan **(March 2014)** • Complete the DHSSPS CAS on ICT **(March 2014)** • Produce quarterly ICT service performance reports **(Oct 2013)** • Support training for RISCP **(Dec 2013)** • Complete annual ICT Staff Satisfaction Survey **(Sept 2013)** • Refresh ICT infrastructure **(March 2014)**		

Supporting Measures of Success

Q = to be reported on quarterly basis
S = to reported on six monthly basis
A = to be reported annually

Minimum of 90% of year 2 ICT actions successfully implemented within timescale from the Information and ICT Strategy (S)

Q2 – 0 actions were due to be implemented

Attainment of substantive compliance with the ICT Controls Assurance Standard (A)

Achieved 82% (substantive compliance)

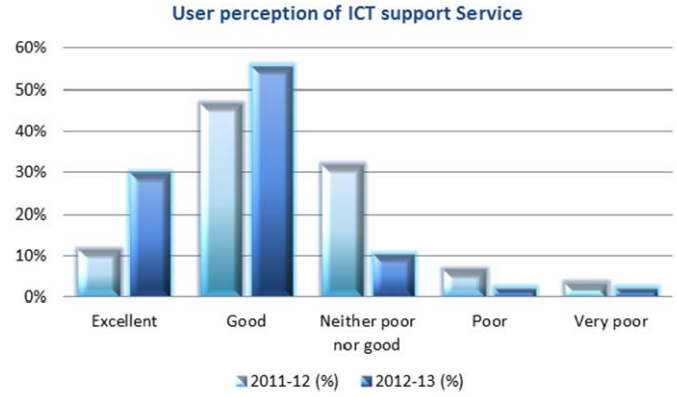
Increase effectiveness level of RQIA's ICT service to 70% by 2015 (Good to Excellent as per staff satisfaction survey) (A)

2013	85% rated the ICT service as excellent/good
2011	58% rated the ICT service as excellent/good

Actions		Progress	Exception Report: Reason/Action/Emerging Risk

Supporting Measures of Success

Q = to be reported on quarterly basis
S = to reported on six monthly basis
A = to be reported annually



<u>9 - Governance</u> - Maintaining and promoting a robust governance and accountability framework

9.1 - Complied with legislative requirements and best practice in relation to governance, risk management and independent assurance

	Actions	Progress	Exception Report: Reason/Action/Emerging Risk
9.1.1	Review and embed RQIAs Risk Management Strategy 2013-14 **(June 2013)**		
9.1.2	Attain substantive compliance with 11 Controls Assurance Standards 2013-14 **(DR) (March 2014)**		
9.1.3	Implement the Internal Audit Plan 2013-14 **(March 2014)**		
9.1.4	Ensure all recommendations from the internal/external audits are progressed and reported to the Audit Committee **(DR) (March 2014)**		
9.1.5	Monitor and review progress on implementation of action plans resulting from legislative, regulatory, licensing or other inspections and inquiries **(DR) (March 2014)**		

Supporting Measures of Success

Q = to be reported on quarterly basis
S = to reported on six monthly basis
A = to be reported annually

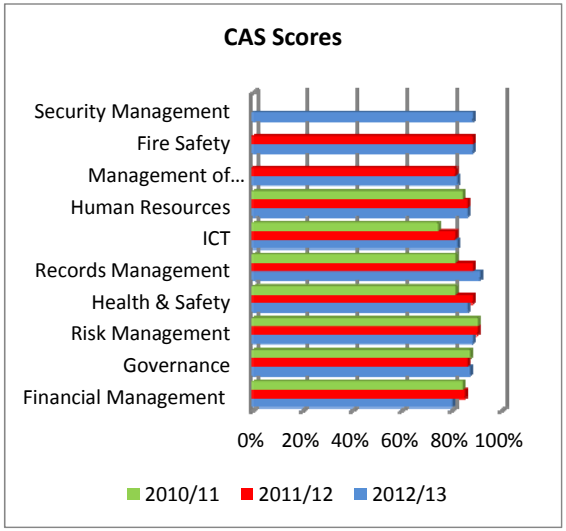
Attainment of a minimum score of 75% to achieve substantive compliance with the 10 Controls Assurance Standards (A)

Standards (2012/13)	Score
Financial Management	80%
Management of Purchasing & Supply	82%
Governance	87%
Risk Management	88%
Health & Safety	86%
Security Management	88%
Fire Safety	88%
Records Management	91%
ICT	82%
Human Resources	86%

Actions		Progress	Exception Report: Reason/Action/Emerging Risk
9.1.6	Complete an annual test of the Business Continuity Plan and implement the amendments **(DR)** **(March 2014)**		
9.1.7	Produce RQIA's Governance Statement and Mid-Year Assurance Statement in accordance with departmental timescales **(DR)** **(March 2014)**		
9.1.8	Prepare and submit the Annual Progress Report on Section 75 of the NI Act 1998 and Section 49A of the Disability Discrimination Order (DDO) 2006 **(Sept 2013)**		
9.1.9	Implement the actions 2013-18 Disability Action Plan **(March 2014)**		
9.1.10	Complete a review of RQIA's Corporate Risk Assurance Framework Report against departmental guidance issued in 2009 **(DR)** **(Sept 2013)**		
9.1.11	Ensure compliance on a timely basis with the documentary requirements		

Supporting Measures of Success

Q = to be reported on quarterly basis
S = to reported on six monthly basis
A = to be reported annually



Minimum of 90% of internal/external audit recommendations successfully implemented within agreed timescale (S)

Q2 – 87% of actions implemented on target
(Based on 3.5 recommendations not implemented on target)

Actions		Progress	Exception Report: Reason/Action/Emerging Risk
	set out in the MSFM **(DR) (March 2014 / On-going)**		
9.1.12	Complete and return RQIA's Board and Audit Committee assessment to the Department **(DR) (Sept 2013)**		

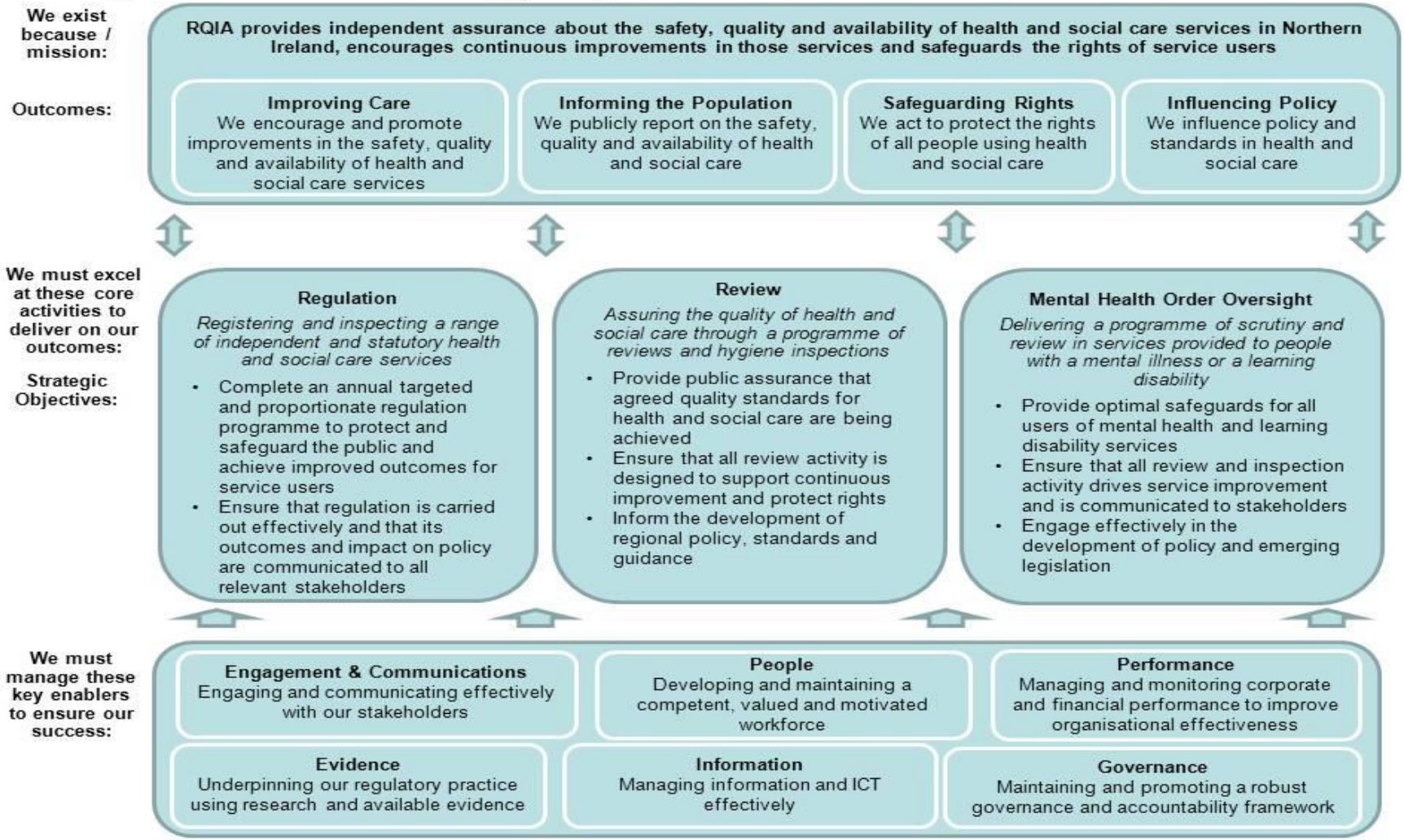
Supporting Measures of Success *Q = to be reported on quarterly basis* *S = to reported on six monthly basis* *A = to be reported annually*
100% of complaints received about RQIA addressed and disseminated to all appropriate staff within the provision of the RQIA Complaints Policy and Procedure (Q)

Q1	0 complaints received
Q2	1 complaints received
Q3	3 complaints received
Q4	

Progress of outstanding actions from RQIA's Corporate Performance Report 2012/13

Actions		Progress	Exception Report: Reason/Action/Emerging Risk
1.1.7	Review and implement the arrangements for the statutory reporting of incidents to RQIA from regulated sector services (to include consideration of the assimilation of information of complaints and notifications from whistle-blowers and other sources). **(September 2012)** **Revised date January 2014**		A corporate policy on complaints management is currently under development. A process mapping workshop has been planned to further develop the policy and should be completed by January 2014.
5.1.9	Develop and facilitate a 2 day skills programme for all regulated sector inspection staff **(December 2012)** **Revised date December 2013**		5 days of training was delivered in October 2013.
6.2.4	Review all finance policies and procedures **(March 2013)** **Revised date March 2014**		Delays with the review of policy and procedures have been caused by the problems with the implementation of the BSTP FPL systems. The policies and procedures will be revised when the implementation of the BSTP system is completed.

Figure 1 - RQIA Strategy Map 2012-15



The Regulation and Quality Improvement Authority

RQIA Board Meeting

Date of Meeting	11 March 2014
Title of Paper	Corporate Risk Assurance Framework Report
Agenda Item	9
Reference	E/02/14
Author	Stuart Crawford
Presented by	Maurice Atkinson
Purpose	The purpose of the Corporate Risk Assurance Framework, which is a combination of the Corporate Risk Register and Corporate Assurance Framework, is to enable RQIA to assure itself that identified risks related to the delivery of key objectives are monitored and managed effectively.
Executive Summary	A detailed change log is enclosed at pages 2 and 3 of the report.
FOI Exemptions Applied	None
Equality Impact Assessment	Not applicable
Recommendation/ Resolution	It is recommended that the Board should **APPROVE** the updated Corporate Risk Assurance Framework Report.
Next steps	The next updated Framework Report will be presented to the Board on 8 May 2014.

The Regulation and Quality Improvement Authority

CORPORATE RISK ASSURANCE FRAMEWORK

Board Meeting: March 2014

CONTENTS **Page**

EXECUTIVE SUMMARY

Risk Log – February 2014				
LOW RISKS	**MEDIUM RISKS**	**HIGH RISKS**	**EXTREME RISKS**	**TOTAL NUMBER OF RISKS**
0	**5**	**0**	**0**	**5**

Risk ID	Description of Change	Details	Date Changed	Risk Rating
Risk 1 There is a risk that in 2013/14 RQIA may not be able to fulfil its statutory requirements or its strategic objectives. This may be caused by additional regulatory activity including urgent unscheduled work being placed on the organisation and the need to achieve further efficiencies which may result in RQIA not providing an adequate level of assurance.	2 Action Dates Amended	• MHLD business case requesting funding for additional staff is produced. Continue to liaise with the Dept to seek approval of the business case. • Regulation business case requesting funding for additional staff is produced. Continue to liaise with the Dept to seek approval of the business case. Dates changed from October 2013 to On-going	18/02/14	**Unchanged**
	1 Action Added	• A report is to be prepared for DHSSPS at their request to set out an analysis of our current inspection methodology and the impact of the lack of investment		
	1 Action Implemented	• Lean project in MHLD registration and inspection admin processes completed.		
Risk 2 There is a risk that the legislation by which RQIA is enabled to access personal confidential information whilst undertaking its prescribed functions might limit the quality and safety assurances which RQIA can provide about services.	1 Action Implemented	Working group has produced accessing personal information guidance.	18/02/14	**Unchanged**
	1 Action Date Amended	• Seek approval of the draft policy and procedure for managing consent. Date changed from Nov 2013 to March 2014		
	2 Actions proposed removed	• Seek approval of the draft policy and procedure for managing consent. • The Head of Information is to provide guidance to all staff/providers.	20/02/14	**Unchanged**

	2 Actions proposed added	• Seek confirmation regarding the Depts. intention for changing the relevant legislation and clarity regarding timescales. • If the legislation remains as it is, seek Board approval for the Head of Information to provide guidance to all staff/providers.	20/02/14	**Unchanged**
(Previously) Risk 4 There is a risk that RQIA will not be able to break even on income and expenditure by 31 March 2014 and the Comptroller & Auditor General may not provide RQIA with an unqualified audit opinion. This may be caused by failings with the implementation of FPL, resulting in RQIA not having accurate financial information on which to base key decisions around forecasting and end of year expenditure.	**RISK REMOVED**	Risk rating downgraded from M/M to L/M and removed from the Corporate Risk Assurance Framework Report as the risk is adequately managed.	07/08/13	**Changed M/M to L/M**
(Previously) Risk 6 There is a risk that RQIA may suffer a loss of some inspection staff that are adversely affected through the introduction of agenda for change revisions to travel claims. This may result in a loss of key experience and knowledge to the organisation.	**RISK REMOVED**	Risk de-escalated to the MHLD, Reviews and Regulation Directorate Risk Registers.	18/02/14	**Unchanged**
(Previously) Risk 7 There is a risk that RQIA may be unable to secure legal representation from the Directorate of Legal Services (DLS), or may have to seek alternative legal representation mid case, in any legal or judicial process in which an HSC Trust is the respondent. This may result in RQIA's legal position being compromised by having used DLS as a source of preliminary advice.	**RISK REMOVED**	Risk de-escalated to the Chief Executive's Office Risk Register.	18/02/14	**Unchanged**

INTRODUCTION

The purpose of the Corporate Risk Assurance Framework, which is a combination of the Corporate Risk Register and Corporate Assurance Framework, is to enable RQIA to assure itself that identified risks related to the delivery of key objectives are monitored and managed effectively. This will also remove duplication and streamline the presentation of risks to the Board and Audit Committee in one composite report.

The Regulation and Quality Improvement Authority (RQIA) Corporate Risk Assurance Framework is drawn from the high level risks identified by the Risk Assessment processes within each directorate and at corporate level.

Extreme (red) and High level (orange) risks have been endorsed by each Director and forwarded for consideration of the Executive Management Team (EMT) for inclusion onto the Corporate Risk Assurance Framework. All other levels of risk (moderate and low) are managed within operational directorates at the relevant level.

Each risk identified is underpinned with a full risk assessment and is set in the context of:
1. A link to a corporate objective or value
2. The potential for serious harm to the organisations strategic business
3. The control measures in place to mitigate against the risk and their strength (low, medium, high, extreme)

An action plan to manage the risk has been devised with a nominated lead, review date and monitoring frequency as detailed in the Corporate Risk Assurance Framework.

RISK ASSURANCE

The development of the Framework has been mandated in "*An Assurance Framework: a Practical Guide for Boards of DHSSPS Arm's Length Bodies*" (DHSSPS, Mar 2009) and the report has been structured as follows:

Principal Objectives - these are the corporate objectives that are crucial to the achievement of RQIA's overall goals.

Principal Risks - defined as those risks that threaten the achievement of the Principal Objectives.

Key Controls - to manage the Principal Risks. Key controls have been documented and ideally they should be subject to scrutiny by independent reviewers e.g. internal/external audit.

Independent Assurance - the key components are ***assurances on controls***, ***gaps in controls*** and ***gaps in assurances***. The most objective assurances are those derived from independent reviewers such as through internal and external audits. This process will enable RQIA to assess whether the assurances identified provide full assurance, reveal any gaps in control, or any gaps in assurance.

Board Reporting - provides an explicit framework for reporting key information to boards. Includes positive information on controls assurance, identification of inadequate controls or where insufficient assurance exists.

Action Plan - actions the organisation will take to narrow the gaps in controls and increase assurance that the principal risks are being effectively managed.

The overall aim of the Corporate Risk Assurance Framework is to put in place a system to demonstrate to the Board that the effectiveness of the controls identified by the EMT is *assured*.

RISK ANALYSIS AND EVALUATION

This risk assessment has been undertaken using:

- the impact that the risk would have on the business should it occur, and
- the likelihood of the risk materialising.

Each risk has then been placed on a risk map to show their relative positions. Further analysis for each risk is detailed including:

- the business impact,
- the controls currently in place to mitigate the risk, and
- any additional actions considered necessary by management.

The risks in the following risk register have been assessed using a risk rating matrix – what is the likelihood of an adverse event occurring given the current level of controls already in place? This has been done using the following table:

Risk likelihood assessment

	Probability	**Description**
Very High (Almost Certain)	1 in 10 chance	Likely to occur
High (Likely)	1 in 100 chance	Will probably occur
Medium (Possible)	1 in 1,000 chance	May occur occasionally
Low (Unlikely)	1 in 10,000 chance	Do not expect to happen
Very Low (Rare)	1 in 100,000 chance	Do not believe will ever happen

The risks have then been assessed in relation to the consequence of this event should it occur. This has been done using the following table:

Risk impact assessment

Level of impact	**Quality/ system failure**	**Public confidence and reputation**	**Complaint or claim**	**Financial loss**
Very Low (Insignificant)	Negligible service deficit, Minor non-compliance, No impact on public health or social care, Minimal disruption to routine organisation activity, No long term consequences	Issue of no public or political concern	Legal challenge, Minor out-of-court settlement	Less than £5,000
Low (Minor)	Significant failure to meet internal standards or follow protocol, No impact on public health or social care Impact on organisation	Local press interest, Local public or political concern	Civil action – no defence Improvement notice	£5,000 - £50,000

Level of impact	Quality/ system failure	Public confidence and reputation	Complaint or claim	Financial loss
	readily absorbed, No long term consequences			
Medium (Moderate)	Repeated failures to meet internal standards or follow protocols, Minimal impact on public health and social care, Impact on the organisation absorbed with significant level of intervention, Minimal long term consequences	Limited damage to reputation, Extended local/ regional press interest, Regional public or political concern	Class action, Criminal prosecution, Prohibition notice	£50,000 - £250,000
High (Major)	Failure to meet national/ professional standards, Significant impact on public health and social care, Impact on the organisation absorbed with some formal intervention by other organisations, Significant long term consequences	Loss of credibility and confidence in the organisation, National press interest, Independent external enquiry, Significant public or political concern	Criminal prosecution – no defence, Executive officer dismissed	£250,000 - £1m
Very high (Catastrophic)	Gross failure to meet professional/ national standards, Major impact on public health and social care Impact on the organisation absorbed with significant formal intervention by other organisations, Major long term consequences	Full public enquiry, Public Accounts Committee hearing, Major public or political concern	Criminal prosecution – no defence, Executive officer fined or imprisoned	More than £1m

Risk Scoring Matrix

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

Once the level of risk is assessed, an appropriate action level is established:

Action levels

Risk level	Action level
Low	Directorate
Medium	Directorate
High	Executive Team/ Board
Extreme	Executive Team/ Board

Inter-relationship between the Corporate and Directorate Risk Registers

The decision as to whether a risk is placed on the Corporate or one of the Directorate Risk Registers should be based on the "Level of Impact/likelihood" of the risk together with a judgement as how best to manage the risk.

1. If the risk is categorised as "low" or "medium" it should be placed on a Directorate Risk Register.

2. If the risk is categorised as "high" or "extreme" is should be placed on the Corporate Risk Register.

3. In some circumstances if the risk is categorised as "medium" the relevant Director should make a judgement as to whether it should be placed on the Corporate or Directorate Risk Register.

If a Director feels the risk and mitigating actions can be adequately managed within their span of authority and control, the risk should be placed on their Directorate Risk Register.

However, if a Director feels the risk and mitigating actions cannot be adequately managed within their span of authority and control and the risk has a genuine corporate dimension i.e. could damage the Authority's reputation, ability to deliver services or financial standing, they should highlight the risk to the EMT. The EMT will consider the risk for inclusion in the Corporate Risk Assurance Framework and decide whether or not it is appropriate to move the risk from a Directorate Risk Register to the Corporate Risk Assurance Framework.

Decisions made by the Executive Team will be recorded in the minutes of EMT meetings and presented to the Audit Committee.

RISK SCORING MATRIX

IMPACT	*Risk Scoring Matrix*				
5 - Very High (VH)					
4 - High (H)					
3 - Medium (M)				1,2,3,4	
2 - Low (L)					
1 - very Low (VL)					
LIKELIHOOD	A - Very low (VL)	B - Low (L)	C - Medium (M)	D - High (H)	E - Very High (VH)

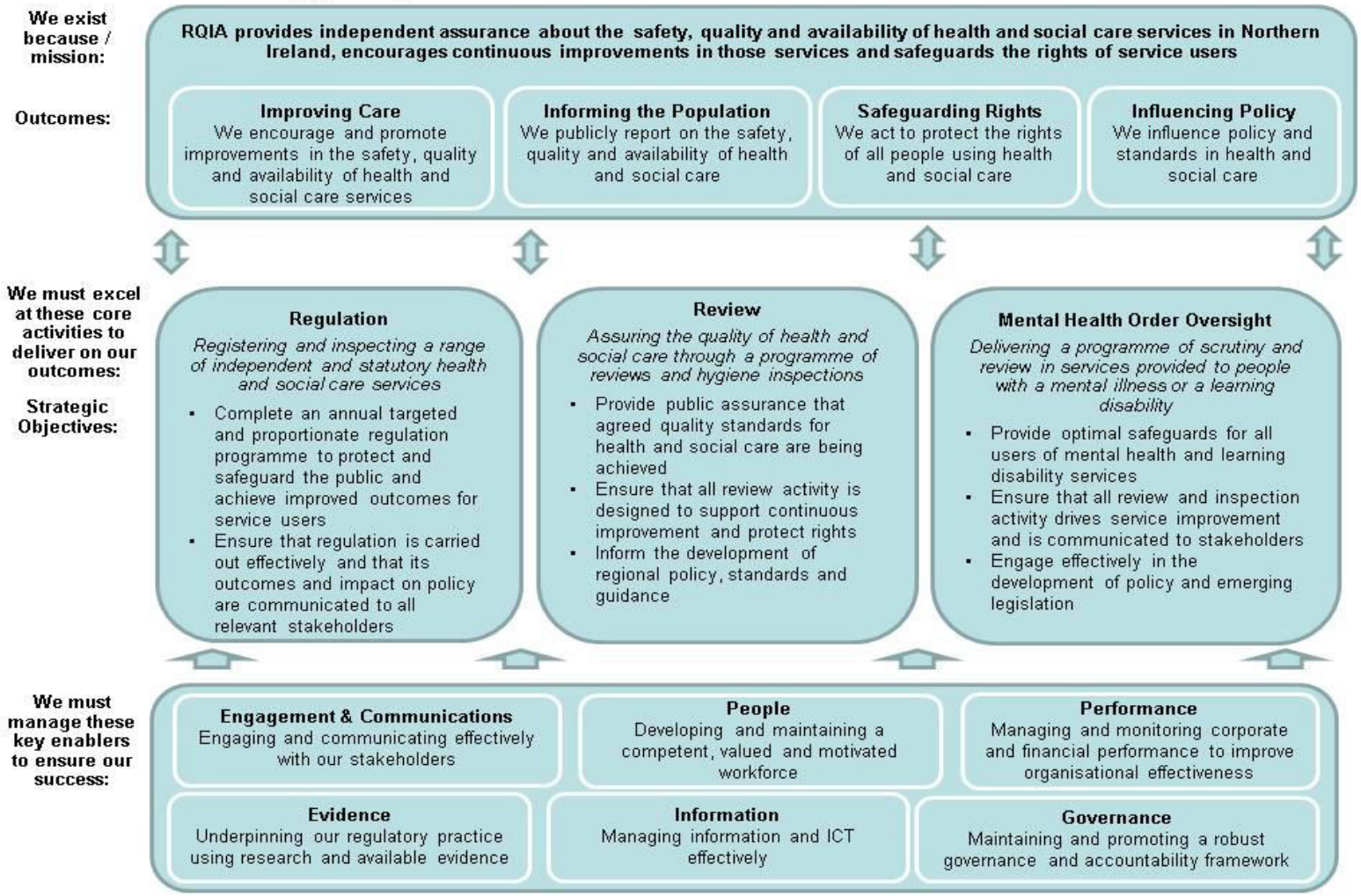
RISK 1 There is a risk that in 2013/14 RQIA may not be able to fulfil its statutory requirements or its strategic objectives. This may be caused by additional regulatory activity including urgent unscheduled work being placed on the organisation and the need to achieve further efficiencies which may result in RQIA not providing an adequate level of assurance.

RISK 2 There is a risk that the legislation by which RQIA is enabled to access personal confidential information whilst undertaking its prescribed functions might limit the quality and safety assurances which RQIA can provide about services.

RISK 3 There is a risk to RQIA's reputation that the existing regulatory and legislative framework fails to keep pace with the rapid introduction of new service delivery models. This may result in in RQIA failing to take appropriate regulatory decisions.

RISK 4 There is a risk that RQIA's function of carrying out inspections of statutory bodies and service providers will be compromised by the use of 'draft' DHSSPS Standards. This may result in an insufficient robust legislative framework against which failings may be identified and could lead to enforcement action.

RQIA Strategy Map 2012-15



RISK ACTIVITY CALENDARS

Action by Date Calendar

Directorates	June-13	July-13	Aug-13	Sept-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	March-14	April-14	May-14	On-going
Chief Executive (CE)													3
Corporate Services (CS)										2			
Regulation & Nursing (R&N)										1			4
MHLD & Social Work (MHLD)													
Reviews (R)													
Executive Management Team (EMT)													

CORPORATE RISK ASSURANCE FRAMEWORK

Ref No.	Description of Risk	Risk Owner	Key Controls	Assurance on Controls	Assessment of Risk			Gaps in Controls	Gaps in Assurances	Action/s Proposed	Action Owner/s	Date
	What would prevent the objective being achieved?	One Person	What controls / systems are in place already to manage the risk	Where can we gain evidence that the controls we are relying on are in place and effective?	Likelihood	Impact	Risk Rating	Where are we failing to put controls / systems in place or are failing to make them effective?	Where are we failing to gain evidence that our controls / systems are in place and effective?	What needs to be done to meet the gaps in controls and assurances?		Action by Date
Principal Objectives: 1.1 Completed an annual targeted and proportionate regulation programme to protect and safeguard the public and achieve improved outcomes for service users 1.2 Ensured that regulation is carried out effectively and that its outcomes and impact on policy are communicated to all relevant stakeholders 2.1 Provided public assurance that agreed quality standards for health and social care are being achieved 2.3 Informed the development of regional policy, standards and guidance 3.1 Provided optimal safeguards for all users of mental health and learning disability services 3.3 Engaged effectively in the development of policy and emerging legislation 6.2 By 2015 we will have aligned resources to support RQIA"s strategic priorities and maintained our financial performance												
1	There is a risk that in 2013/14 RQIA may not be able to fulfil its statutory requirements or its strategic objectives. This may be caused by additional regulatory activity including urgent unscheduled work being placed on the organisation and the need to achieve further efficiencies which may result in RQIA not providing an adequate level of assurance.	CE	• Monthly financial reporting to DHSSPS and Executive Team (includes forecasting of deficit/surplus) • Monthly budgetary information provided to Directors • Payroll budgets developed at Directorate and team levels. • Bi-monthly reporting of financial position to Board. • Currently implementing RQIA's Improvement and Efficiency Plan 2011-2015. • Routine reporting to budget holders at team level • RPSG reviews on a	• Corporate Performance Report produced and presented quarterly to RQIA's Board.	H	M	M			• MHLD business case requesting funding for additional staff is produced. Continue to liaise with the Dept to seek approval of the business case. • Regulation business case requesting funding for additional staff is produced. Continue to liaise with the Dept to seek approval of the business case. • A report is to be prepared for DHSSPS at their request to set out an analysis of our current inspection methodology and the impact of the lack of investment	MHLD Director R&N Director R&N Director	On-going On-going March 2014

Ref No.	Description of Risk	Risk Owner	Key Controls	Assurance on Controls	Assessment of Risk			Gaps in Controls	Gaps in Assurances	Action/s Proposed	Action Owner/s	Date
	What would prevent the objective being achieved?	One Person	What controls / systems are in place already to manage the risk	Where can we gain evidence that the controls we are relying on are in place and effective?	Likelihood	Impact	Risk Rating	Where are we failing to put controls / systems in place or are failing to make them effective?	Where are we failing to gain evidence that our controls / systems are in place and effective?	What needs to be done to meet the gaps in controls and assurances?		Action by Date
			monthly basis the delivery of the review programme against the planned schedule. If an additional review is commissioned this may result in rescheduling of planned activity. • Regulation Directorate keep under regular review changes in the planned programme of inspection as a result of emerging risks in the sector. The Directorate will continue to place an emphasis on services identified as high risk. • The MHLD Directorate reviews on a regular basis the delivery of its inspection programme against the agreed schedule and re-prioritises the work programme as required. • Allocation letter for dental funding received on 2 July										

Ref No.	Description of Risk	Risk Owner	Key Controls	Assurance on Controls	Assessment of Risk			Gaps in Controls	Gaps in Assurances	Action/s Proposed	Action Owner/s	Date
	What would prevent the objective being achieved?	One Person	What controls / systems are in place already to manage the risk	Where can we gain evidence that the controls we are relying on are in place and effective?	Likelihood	Impact	Risk Rating	Where are we failing to put controls / systems in place or are failing to make them effective?	Where are we failing to gain evidence that our controls / systems are in place and effective?	What needs to be done to meet the gaps in controls and assurances?		Action by Date
			2012. • Established review arrangements for planning the review programme. • Have completed a recruitment pool for sessional inspectors. • Lean project in MHLD registration and inspection admin processes completed.									

Ref No.	Description of Risk	Risk Owner	Key Controls	Assurance on Controls	Assessment of Risk			Gaps in Controls	Gaps in Assurances	Action/s Proposed	Action Owner/s	Date
	What would prevent the objective being achieved?	One Person	What controls / systems are in place already to manage the risk	Where can we gain evidence that the controls we are relying on are in place and effective?	Likelihood	Impact	Risk Rating	Where are we failing to put controls / systems in place or are failing to make them effective?	Where are we failing to gain evidence that our controls / systems are in place and effective?	What needs to be done to meet the gaps in controls and assurances?		Action by Date
Principal Objectives: 8.1 By 2015 we will have ensured that information is managed effectively to support RQIA's strategic and operational objectives 8.2 By 2015 we will have complied with best practice and the highest standards of information governance												
2	There is a risk that the legislation by which RQIA is enabled to access personal confidential information whilst undertaking its prescribed functions might limit the quality and safety assurances which RQIA can provide about services.	CE	• RQIA has received legal advice regarding the 2003 order. • RQIA position paper sent to DHSSPSNI in respect of the impact on capacity to regulate and review. • Meeting held with Legal Advisors to discuss the draft policy and procedure. • Interim advice received from the Permanent Secretary. • A representative short life working group is established and met in July and Dec 2012. • A report detailing the progress of the short life working group was presented at the Board Workshop in Feb 2013. • The suggestions from the short life working group to		H	M	M	• Need to produce guidance to RQIA staff and service providers/users • Need to have further dialogue with the Sponsor Branch regarding necessary changes to the 2003 Order.		• Seek confirmation regarding the Depts. intention for changing the relevant legislation and clarity regarding timescales. • If the legislation remains as it is, seek Board approval for the Head of Information to provide guidance to all staff/providers.	R&N Director and Head of Information Head of Information	TBC with Dept TBC with Dept

Ref No.	Description of Risk	Risk Owner	Key Controls	Assurance on Controls	Assessment of Risk			Gaps in Controls	Gaps in Assurances	Action/s Proposed	Action Owner/s	Date
	What would prevent the objective being achieved?	One Person	What controls / systems are in place already to manage the risk	Where can we gain evidence that the controls we are relying on are in place and effective?	Likelihood	Impact	Risk Rating	Where are we failing to put controls / systems in place or are failing to make them effective?	Where are we failing to gain evidence that our controls / systems are in place and effective?	What needs to be done to meet the gaps in controls and assurances?		Action by Date
			mitigate this risk within the current legislative framework were presented to the Board Meeting in March 2013 • HOI consulted with ICO and Legal in April 2013 regarding the drafts. • HOI consulted with providers June/July 2013. • Working group has produced accessing personal information guidance.									

Ref No.	Description of Risk	Risk Owner	Key Controls	Assurance on Controls	Assessment of Risk			Gaps in Controls	Gaps in Assurances	Action/s Proposed	Action Owner/s	Date
	What would prevent the objective being achieved?	One Person	What controls / systems are in place already to manage the risk	Where can we gain evidence that the controls we are relying on are in place and effective?	Likelihood	Impact	Risk Rating	Where are we failing to put controls / systems in place or are failing to make them effective?	Where are we failing to gain evidence that our controls / systems are in place and effective?	What needs to be done to meet the gaps in controls and assurances?		Action by Date
Principal Objectives: 1.1 Completed an annual targeted and proportionate regulation programme to protect and safeguard the public and achieve improved outcomes for service users 1.2 Ensured that regulation is carried out effectively and that its outcomes and impact on policy are communicated to all relevant stakeholders 2.1 Provided public assurance that agreed quality standards for health and social care are being achieved 2.3 Informed the development of regional policy, standards and guidance 3.1 By 2015 we will have provided optimal safeguards for all users of mental health and learning disability services 3.2 By 2015 we will have ensured that all review and inspection activity drives service improvement and is communicated to stakeholders												
3	There is a risk to RQIA's reputation that the existing regulatory and legislative framework fails to keep pace with the rapid introduction of new service delivery models. This may result in in RQIA failing to take appropriate regulatory decisions.	CE	• Paper sent to the Dept about the difficulties in regulating supported living in July 2012. • RQIA is participating in the DHSSPS(NI) working groups to revise and update the minimum standards in: ➢ Children's Homes ➢ Independent Health Care ➢ Nursing Homes • Have made formal response to DHSSPS/HSC Board on the 'Transforming Your Care: Vision to Action' consultation. • Currently participating in a multi-agency group examining the regulatory framework in supported living services.	• Corporate Performance Report detailing progress against the Corporate Strategy is presented to the Board quarterly.	H	M	M			• Liaise with the Department to assess the impact of Transforming Your Care on regulation and agree actions to ensure a regulatory framework is in place which is fit for purpose.	CE	On-going

Ref No.	Description of Risk	Risk Owner	Key Controls	Assurance on Controls	Assessment of Risk			Gaps in Controls	Gaps in Assurances	Action/s Proposed	Action Owner/s	Date
	What would prevent the objective being achieved?	One Person	What controls / systems are in place already to manage the risk	Where can we gain evidence that the controls we are relying on are in place and effective?	Likelihood	Impact	Risk Rating	Where are we failing to put controls / systems in place or are failing to make them effective?	Where are we failing to gain evidence that our controls / systems are in place and effective?	What needs to be done to meet the gaps in controls and assurances?		Action by Date
Principal Objectives: 1.1 Completed an annual targeted and proportionate regulation programme to protect and safeguard the public and achieve improved outcomes for service users 1.2 Ensured that regulation is carried out effectively and that its outcomes and impact on policy are communicated to all relevant stakeholders												
4	There is a risk that RQIA's function of carrying out inspections of statutory bodies and service providers will be compromised by the use of the DHSSPS Draft Minimum Standards particularly Independent Healthcare and Children's Services. This may result in a challenge to enforcement taken by RQIA on the basis of these draft standards.	R&N	• On-going dialogue with DHSSPS to review the draft standards. • DHSSPS has established a process and timeframe for review of the draft Independent Healthcare minimum standards. • DHSSPS has established a process and timeframe for review of the draft Children's Services minimum standards. • Sector acceptance of draft standards • Access to legal advice. • Formal enforcement action is taken on the basis of the regulations. • New enforcement policy was approved by RQIA's Board in March 2013.	• Formal enforcement action is determined in the first instance by the relevant HoP in consultation with the Director of R&N and legal advice is sought when required. • All registered services subject to enforcement action has the right to representation to the RQIA. • All registered services subject to notice of decision to impose additional conditions, or to vary or cancel registration has right of appeal to the Care Tribunal.	H	M	M			• RQIA has nominated officers to attend the working groups led by the DHSSPS to revise and update the draft minimum standards.	Director R&N	On-going

The Regulation and Quality Improvement Authority

RQIA Board Meeting

Date of Meeting	11 March 2014
Title of Paper	**Draft RQIA Strategy Map 2015-18**
Agenda Item	10
Reference	F/ 02 /14
Author	Maurice Atkinson
Presented by	Maurice Atkinson
Purpose	The purpose of this paper is to present the current thinking on the draft Strategy Map 2015-18 for consideration and approval by the Board. Endorsement of the draft Map will enable us to move to the next stage of developing the full draft Corporate Strategy 2015-18.
Executive Summary	The new draft Strategy Map 2015-18 has been developed in January/February based on best practice in this area and through consultation with staff in all Directorates. It was also considered by the Strategy Steering Group on 27 February. Whist the fundamentals of the current Map hold good, the following changes have been made: 1. New format/layout of the Map. Colour has been used as a device to unify the Map and emphasise its coherence. 2. The Map is now more holistic and fully integrated with the addition of a Vision Statement and Values. 3. The wording of the Vision Statement has been revised and strengthened. 4. The wording of the Purpose Statement has been simplified and now includes reference to RQIA as an independent regulator and informing the population through the publication of our reports. The Purpose Statement has also been aligned with RQIA's strapline i.e. Assurance, Challenge and

	Improvement. 5. A Stakeholder Outcomes perspective has been added to the Map. 6. The Stakeholder Outcomes perspective on the Map has been aligned with the 3 interconnected domains of quality in Q2020 i.e. effective care, safe care and positive patient/client experience of care. This modernises the language on the Map and ensures a fit with a long-term regional strategy. The definitions of Safe Care, Effective Care and Compassionate Care are taken directly from Q2020. 7. The 3 Core Activities remain the same, but the description of each Core Activity has been updated. The heading "*Monitoring Mental Health Legislation*" as a Core Activity future-proofs the work of the MHLD Directorate in the context of the anticipated introduction of new Mental Health Capacity legislation during the lifetime of the new Strategy. 8. "*Evidence*" as a Strategic Enabler has been subsumed within each of the Core Activities 9. The wording and description of all of the Strategic Enablers have been revised. The most important development is the addition of a "*Stakeholder Outcomes*" perspective on the Map, alignment with Q2020 and framing the 3 interconnected domains of quality as questions. This is intended to articulate the outcomes we will achieve for stakeholders through the delivery of our regulatory functions. These Stakeholder Outcomes will in turn be transferred on to the new Corporate Scorecard and corresponding Measures of Success (MoS) will be developed.
FOI Exemptions Applied	None
Equality Impact Assessment	Not Applicable

Recommendation/ Resolution	The Board is asked to **APPROVE** the draft Strategy Map 2015-18.
Next steps	Development of the draft Corporate Strategy 2015-18 based on the agreed draft Strategy Map.

Draft RQIA Strategy Map 2015-18 – Board Meeting 11 March 2014

Vision

To be a driving force for improvement in the quality of health and social care in Northern Ireland

Purpose

RQIA is the independent health and social care regulator in Northern Ireland

We provide assurance about the quality of care, challenge poor practice, promote improvement, safeguard the rights of service users and inform the public through the publication of our reports

Stakeholder Outcomes

Our stakeholders require us to make independent and robust assessments to decide whether care is being provided safely, effectively and compassionately:

Is Care Safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them

Is Care Effective?

The right care, at the right time in the right place with the best outcome

Is Care Compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support

Core Activities

Regulation

Registering and inspecting regulated health and social care services to maintain and promote quality improvement

Review

Carrying out a programme of reviews and inspections of statutory health and social care services to maintain and promote quality improvement

Monitoring Mental Health Legislation

Inspecting and reviewing mental health and learning disability services to promote improvement and safeguard the rights of service users

Strategic Enablers

Engagement & Communications

Engaging with our stakeholders to build strong relationships and involvement in our work

People

Developing and maintaining a competent, engaged and a high performance workforce

Sustainable Performance

Setting strategic direction, maintaining financial performance and focusing on continuous improvement

Governance

Promoting and delivering robust governance and accountability

Information & ICT

Building and maintaining effective and customer-focused information and ICT services

Values

Independence ◇ Inclusiveness ◇ Integrity ◇ Accountability ◇ Professionalism ◇ Effectiveness

The Regulation and Quality Improvement Authority

RQIA Board Meeting

Date of Meeting	11 March 2014
Title of Paper	**Proposal to Develop a Corporate Scorecard**
Agenda Item	11
Reference	G/ 02/ 14
Author	Maurice Atkinson
Presented by	Maurice Atkinson
Purpose	The purpose of this paper is to explain the concept of the Public Sector Scorecard (PSS) and to seek Board approval for the development of a tailored Corporate Scorecard based on this framework.
Executive Summary	This Paper outlines the background to the proposal, explains the concept of the PSS and its benefits, suggests a template for a tailored Corporate Scorecard and identifies next steps and risks in deploying a scorecard approach to performance management. The Paper recommends the adoption of the PSS as a performance management framework and as the basis for the development of a tailored Corporate Scorecard.
FOI Exemptions Applied	None
Equality Impact Assessment	Not Applicable
Recommendation/ Resolution	The Board is asked to **APPROVE** the proposal to adopt the Public Sector Scorecard (PSS) and develop a tailored Corporate Scorecard.
Next steps	Development and implementation of a Corporate Scorecard for 2015-16.

The Regulation and Quality Improvement Authority

Proposal to Develop a Corporate Scorecard

Version 1.0; 11 March 2014

Contents

Proposal to Develop a Corporate Scorecard

1. Introduction

The Board is asked to consider and approve the adoption of the Public Sector Scorecard (PSS) as a performance management framework and as the basis for the development of a tailored Corporate Scorecard from 2015/16 onwards.

> ***"Measurement done right can transform your organisation. It is my contention that there are certain performance measures and ways of measuring that can have a transformational impact on the way people in organisations view their work, their products, and their customers…This transformation doesn't require a major change in your business structure or systems—but only in the way you think about measuring your organisation."*** – Dean R. Spitzer, *Transforming Performance Measurement* (2007)

2. Background

Building a High Performance Culture

RQIA's approach to building a high performance culture is based on the 4 pillars of strategic planning, continuous improvement, organisational development and performance management[1].

This holistic approach is illustrated in Figure 1.

[1] See RQIA's Performance Management Framework (2013) and Maurice Atkinson, (2012) "Developing and using a performance management framework: a case study", Measuring Business Excellence, Vol. 16 Iss: 3, pp.47 - 56

Figure 1: RQIA's Approach to Building a High Performance Culture

These approaches are underpinned by the use of tools and techniques such as strategy mapping, risk management, the EFQM Business Excellence Model, Lean, Investors in People, Staff Surveys/Focus Groups, Culture Charter, Measures of Success, appraisals/PDPs and performance reporting using a traffic lights system/exception reporting.

Performance management is therefore of crucial importance as part of the overall approach to building and embedding a high performance culture within RQIA.

Review of Measures of Success

Measures of Success (MoS) are qualitative and quantitative data that help the organisation to gain insights, make better-informed decisions and improve performance. Whist MoS are directly linked to strategic objectives, critically they should also be developed in terms of RQIA's 4 key outcomes – Improving Care, Informing the Population, Safeguarding Rights and Influencing Policy – identified on the Strategy Map 2012-15 (Appendix 1).

A review of MoS was undertaken in 2013 and the outcome of this review was reported to the Board at a workshop in December. The main findings of the review and the EFQM assessment in 2012 were that the indicators are predominately operational and there is a disconnect between RQIA's performance indicators and the 4 key outcomes identified on the Strategy Map.

Whilst the new suite of Measures of Success incorporated into the 2014/15 Business Plan is more robust and relevant, the shortcomings identified above still persist. In addition we have what might be viewed as a high number of performance indicators i.e. 53. Of course there is no right answer to the question of how many measures should be used by an organisation. However, what is important is that we develop the right measures, preferably a small number, aligned to our strategy and which are of critical importance to the long-term success of RQIA.

> ***"Measuring more is easy, measuring better is hard."*** – Charles Handy

3. Public Sector Scorecard

Why use a Scorecard Approach?

Neely, Adams and Crowe[2] state that "*traditionally it has been argued that measures should be derived from strategy. In fact this is wrong. The only reason an organisation has a strategy is to deliver value to some set of stakeholders. The starting point has to be: `'Who are the stakeholders and what do they want and need?*"" Whilst the RQIA Strategy Map has been developed on the basis of the value we deliver to our stakeholders, the focus on aligning MoS to Strategic Objectives may have inhibited us from developing stakeholder and outcome focused indicators. This may also have had the effect of the development of MoS in functional silos, although there may be a certain inevitability about this.

Therefore the adoption of a best practice performance measurement framework needs to be considered e.g. the Balanced Scorecard (BSC)[3], Performance Prism[4], Public Sector Scorecard (PSS)[5] etc. in order to re-focus the organisation on the development of outcome-based indicators from the perspective of RQIA's stakeholders.

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[2] Andy Neely, Chris Adams and Paul Crowe, Measuring Business Excellence 5, 2 2001, pp. 6-1 2

[3] Kaplan, R.S. and Norton, D.P. (1996). *The Balanced Scorecard: Translating Strategy into Action.* Harvard Business School Press, Boston, MA.. The Balanced Scorecard is a strategic performance management framework that has been designed to help an organisation monitor its performance and manage the execution of its strategy. In its simplest form the Balanced Scorecard breaks performance monitoring into four interconnected perspectives: **Financial**, **Customer**, **Internal Processes** and **Learning & Growth**.

[4] Neely, A, Adams, C and Kennerley, M (2002) *The performance prism: the scorecard for measuring and managing business success,* Financial Times Prentice Hall, London. The Performance Prism is a second generation performance management framework. It aims to manage the performance of an organisation from five interrelated "facets" i.e. **Stakeholder Satisfaction** – who are our stakeholders and what do they want? **Stakeholder Contribution** – what do we want and need from our stakeholders? **Strategies** – what strategies do we need to put in place to satisfy the wants and needs of or our stakeholders while satisfying our own requirements too? **Processes** – what processes do we need to put in place to enable us to execute our strategies? **Capabilities** – what capabilities do we need to put in place to allow us to operate our processes?

[5] Max Moullin, Director, Public Sector Scorecard Research Centre, Sheffield, UK, www.publicsectorscorecard.co.uk

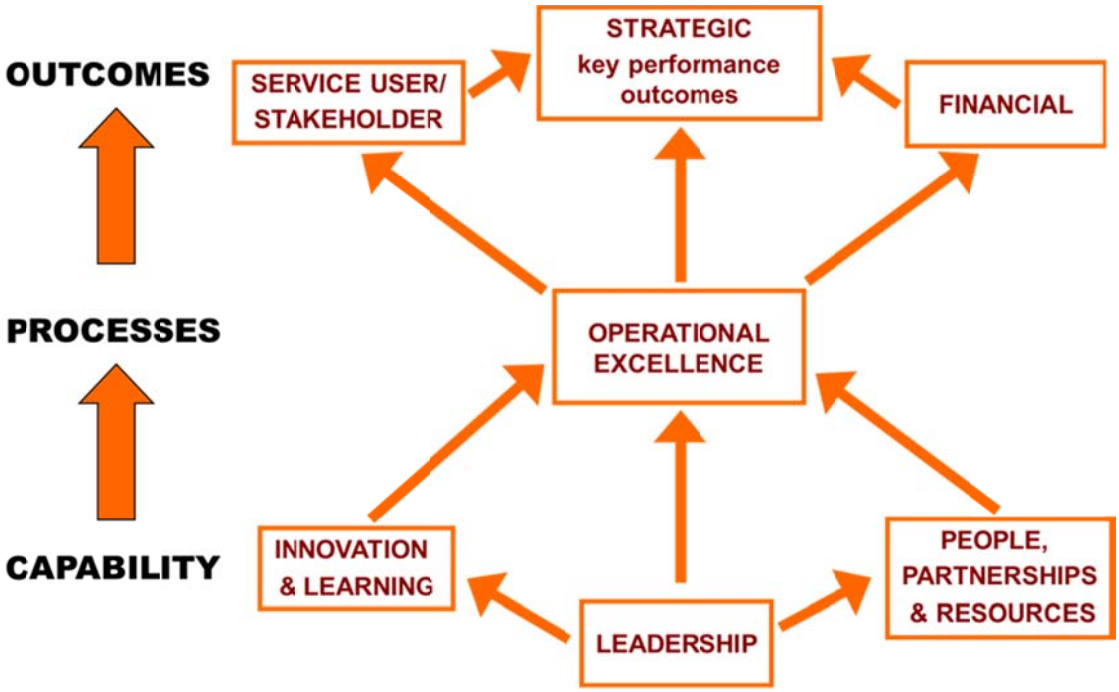
What is the Public Sector Scorecard?

The Public Sector Scorecard (PSS) is an integrated performance management framework that adapts and extends the principles of the Balanced Scorecard and Performance Prism for the public and third sectors. The PSS has been used in central and local government as well as healthcare.

Originally developed in 2001, the PSS focuses on the outcomes that matter to service users, the processes that deliver these outcomes, and the organisation's capability to support its people and processes to achieve the relevant outcomes.

Figure 2 illustrates the PSS framework.

Figure 2: The Public Sector Scorecard (PSS)



In essence the PSS is a performance management framework which "*depict[s] the relationships between capability, process and outcome elements*".[6] Thus processes lead to outcomes, while capability - defined as the organisational, cultural and resource-based factors that need to be addressed for processes to work effectively - leads to effective processes.

The right hand side of Figure 2 provides more detail on the different elements. Outcomes include the key performance outcomes that the organisation aims to achieve, those required by users and other key stakeholders, together with financial outcomes such as breaking-even, securing funding, and offering value

[6] Moullin, M. (2009) Using the Public Sector Scorecard to measure and improve healthcare services. *Nursing Management*, September 2009, Vol. 16, No.5, pp.26-31

for money. There will be a variety of processes within an organisation and the PSS aims to help organisations achieve operational excellence so that they can achieve the various outcomes. Capability comprises what needs to be done to support staff and processes in delivering the outcomes required. This might include trained and motivated people, good partnership working and sufficient resources, together with a culture based on innovation and learning rather than a blame culture - all underpinned by effective and supportive leadership.

Benefits

The benefits of adopting the PSS are that it:

- is a sophisticated and integrated version of a scorecard which has been designed specifically for the public and voluntary sectors;
- adapts and extends the Balanced Scorecard and Performance Prism;
- broadly aligns with our Strategy Map and the EFQM Business Excellence Model;
- captures the voice of stakeholders, focusing on outcomes and evidence-based drivers of outcomes;
- facilitates the development of a broad and balanced portfolio of measures;
- focuses attention on the "vital few" measures critically important to RQIA;
- allows the organisation to monitor progress and improve its performance in relation to capability, processes and outcomes; and
- aims to assist in developing a culture of improvement, innovation and learning.

4. Corporate Scorecard

Draft Corporate Scorecard Template

The PSS is a flexible framework and the seven perspectives can be ignored or changed according to the needs of the organisation, provided that they address outcomes, processes and capability as illustrated in the first column of Figure 2. The adoption of the PSS will therefore allow us to develop a scorecard that is tailored to reflect the specific needs of RQIA.

A draft template for the Corporate Scorecard has been developed based on the PSS (see Appendix 2). This will be subject to further tailoring as part of the development and refinement of a Scorecard specific to RQIA.

The new Corporate Scorecard will require us to develop measures in relation to Outcomes, Processes and Organisational Capabilities:

- **Outcomes** – (i) How do we demonstrate to our stakeholders that RQIA's programme of work is driving improvements in the quality of health and social care in Northern Ireland? (ii) In the view of our stakeholders are we delivering on our outcomes and involving them appropriately in our work? (iii) Are we achieving and will we continue to achieve strong financial performance?

- **Processes** – What critical processes do we need to put in place to enable us to achieve these key performance outcomes? How can they be improved? Are there innovative ways of achieving these outcomes better?

- **Organisational Capabilities** - What capabilities do we require if we are to operate and improve these processes and achieve our key performance outcomes?

Thus MoS will be developed in order to answer these questions about organisational performance.

> *"**Fundamentally we have to move away from thinking about measurement in the traditional sense – the process of quantification – and start to think about measurement as the process of gathering management intelligence**."* – Neely, A, Adams, C and Kennerley, M (2002) *The performance prism: the scorecard for measuring and managing business success*

5. Next Steps

Key Tasks

Key steps in the full development of a Corporate Scorecard are as follows:

- Development of the Draft RQIA Strategy Map 2015-18 which will include the identification of outcomes from the perspective of the organisation's multiple stakeholders. It is critically important that the difference between inputs, activities, outputs, outcomes and impact is understood so that appropriate outcomes are identified for a regulatory organisation (see Appendix 3 for guidance on this[7]);

- Formation of a small, representative Working Group tasked with developing a Corporate Scorecard;

- Align the Scorecard with the outcomes identified on the Strategy Map and agree the other dimensions of performance which are relevant and meaningful to RQIA;

- Develop a balanced suite of measures to populate the Scorecard. It is essential that the overall number of measures is restricted in order to create a critical focus on the strategic performance of the organisation;

[7] Put simply "outcomes" are the difference made by "outputs." A useful distinction between Level 1 and Level 2 outcome measures was developed as part of the review of MoS. An example of a Level 1 outcome measure is the number of recommendations / requirements implemented by a service provider. A Level 2 outcome measure relates to what difference or impact the implementation of recommendations / requirements has made to the model and delivery of care to patients/clients. It is recognised that the evaluation and use of Level 2 outcome measures is highly complex and particularly problematic for a regulator who *ipso facto* does not have control of the end-to-end processes in relation to the strategic commissioning, financing and delivery of care.

- Complete the MoS Template[8] for each of the agreed measures (see Appendix 4);

- Review the Scorecard and seek Board approval;

- Use the Scorecard to improve decision-making and organisational performance;

- Refine and refresh the Scorecard on an ongoing basis to ensure MoS remain relevant to the needs of RQIA; and

- Communicate to the public and our key stakeholders the difference we are making as an organisation.

The Strategy Steering Group will oversee the development of the Corporate Scorecard.

Risks to the Adoption of the PSS

Neely and Bourne[9] give four main reasons why measurement initiatives fail - inappropriate design of the measurement system, failure in implementation, spending a lot of money developing lots of measures but ignoring those that are most important, and not doing anything with the information that is obtained.

The experience of trying to implement and embed a performance management system in RQIA since 2009 confirms that the successful development and deployment of appropriate and effective performance measures can be problematic and elusive. Therefore the risks inherent in the development and implementation of a Corporate Scorecard need to be fully recognised and mitigated from the outset of this initiative.

It is therefore essential that the Board, Chief Executive and Directors demonstrate commitment to the development and use of a Scorecard and that there are change agents in each Directorate to ensure the Scorecard approach is successfully embedded in RQIA.

Reporting Performance

Reporting of organisational performance using the Scorecard will continue to be on a quarterly basis via the RQIA Corporate Performance Report.

It is vital that the Scorecard is used by the Board and Executive Team as part of a performance review which triggers a debate about the fundamental challenges and issues facing RQIA. The Scorecard should enable pertinent questions to be asked about how we are doing and where we are going as an organisation. Thus

[8] Neely, A.D. (1998) “Measuring Business Performance: Why, What, How”, Economist Books, London.
[9] Neely, A., Bourne, M., 2000, "*Why measurement initiatives fail*", Measuring Business Excellence, 5, 2, 6-13.

Kaplan and Norton note that "*the real power of [a Scorecard] … occurs when it is transformed from a measurement system to a management system*[10]"

6. Conclusion

The PSS has been described as "*groundbreaking*" by a former head of research at the New York Senate.[11] As the creator of the PSS, Max Moullin states "… a *particular benefit of the PSS is that it … [encourages] staff to focus on … desired outcomes.*"[12] Further he warns that all measures and targets should be based on outcomes or evidence-based drivers of outcomes or they should be scrapped.[13]

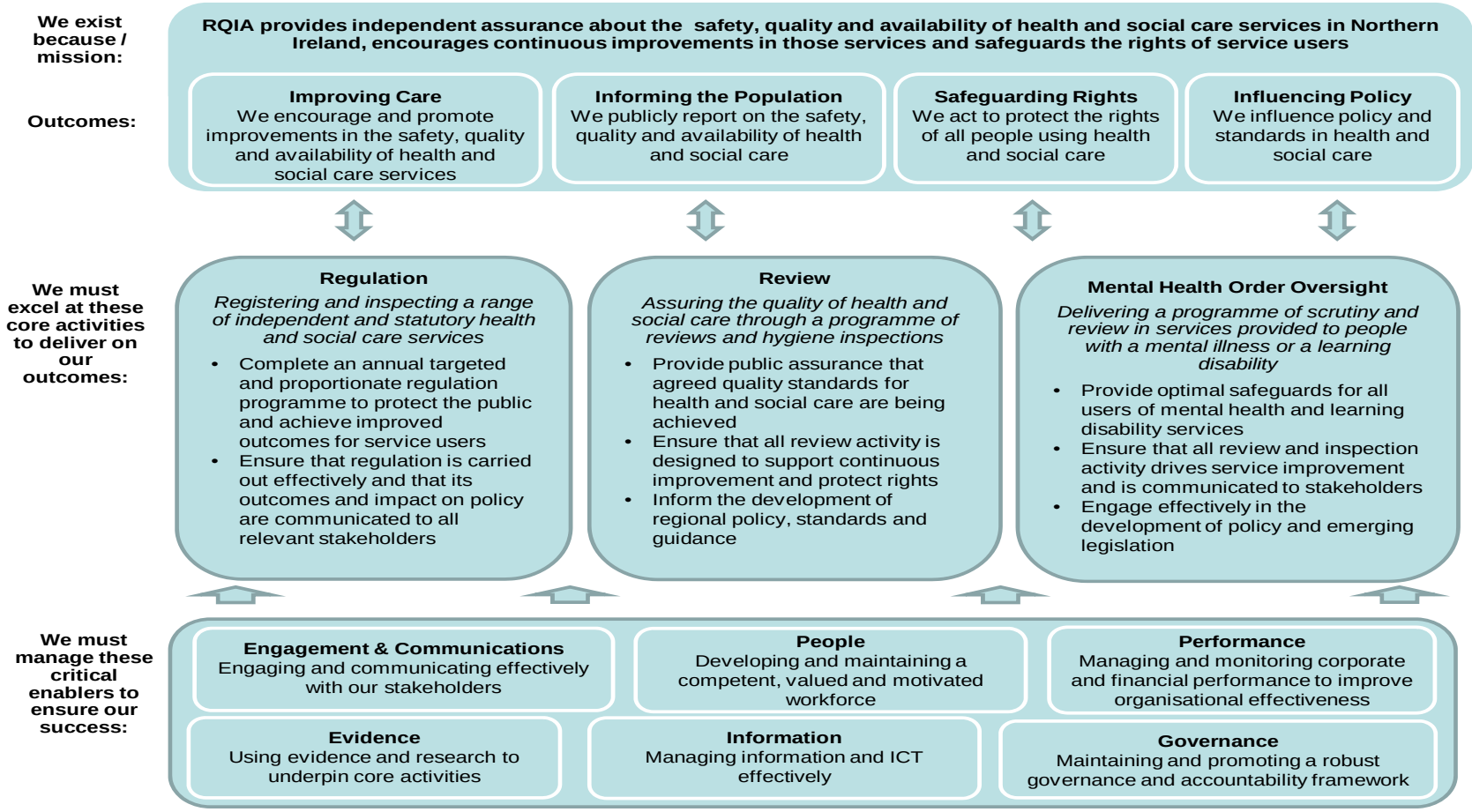
It is recommended that RQIA should adopt the PSS and develop its own tailored scorecard as part of the development of the RQIA Corporate Strategy 2015-18. One of the key success factors for the development of the Scorecard is engagement with internal and external stakeholders in order to ensure that a meaningful and sustainable approach to performance management is embedded within the organisation.

> ***"The scorecard should tell the story of the strategy … Thus, a successful Scorecard is one that communicates a strategy through an integrated set of financial and non-financial measurements … By building the management system around the scorecard framework, [the organisation] can achieve the ultimate payoff – translating the strategy into action."*** – Kaplan, R.S. and Norton, D.P., *The Balanced Scorecard: Translating Strategy into Action (1996)*

[10] Kaplan, R.S. and Norton, D.P. (1996). *The Balanced Scorecard: Translating Strategy into Action.* Harvard Business School Press, Boston, MA.
[11] Penna, B. (2011) *The Nonprofit Outcomes Toolbox: A Complete Guide to Program Effectiveness, Performance Measurement, and Results.* John Wiley and Sons, Hoboken, New Jersey.
[12] Moullin, M and Copeland, R (2013) Implementing and evaluating behaviour change programmes with the Public Sector Scorecard. *National Health Executive*, Jul-Aug 2013, pp.16-18
[13] Moullin, M. (2009) What's the score? Feature Article, *Public Finance*, 21 May, Chartered Institute of Public Finance and Accountancy, London.

Appendix 1 – RQIA Strategy Map 2012-15

Figure 1: RQIA Strategy Map 2012-15



Appendix 2 – Draft Corporate Scorecard Template

Outcomes (i) How do we demonstrate to our stakeholders that RQIA's programme of work is driving improvements in the quality of health and social care in Northern Ireland? (ii) In the view of our stakeholders are we delivering on our outcomes and involving them appropriately in our work? (iii) Are we achieving and will we continue to achieve strong financial performance?			
[DN: Insert "*Stakeholder Outcomes*" from Strategy Map 2015-18 here]	***Measures of Success***		
	Measure (including frequency of reporting: M, Q, S, A)	***Target***	***Progress***

Outcomes

(i) How do we demonstrate to our stakeholders that RQIA's programme of work is driving improvements in the quality of health and social care in Northern Ireland?

(ii) In the view of our stakeholders are we delivering on our outcomes and involving them appropriately in our work?

(iii) Are we achieving and will we continue to achieve strong financial performance?

	Measures of Success		
	Measure (including frequency of reporting: M, Q, S, A)	***Target***	***Progress***
Stakeholder Voice			

Outcomes

(i) How do we demonstrate to our stakeholders that RQIA's programme of work is driving improvements in the quality of health and social care in Northern Ireland?

(ii) In the view of our stakeholders are we delivering on our outcomes and involving them appropriately in our work?

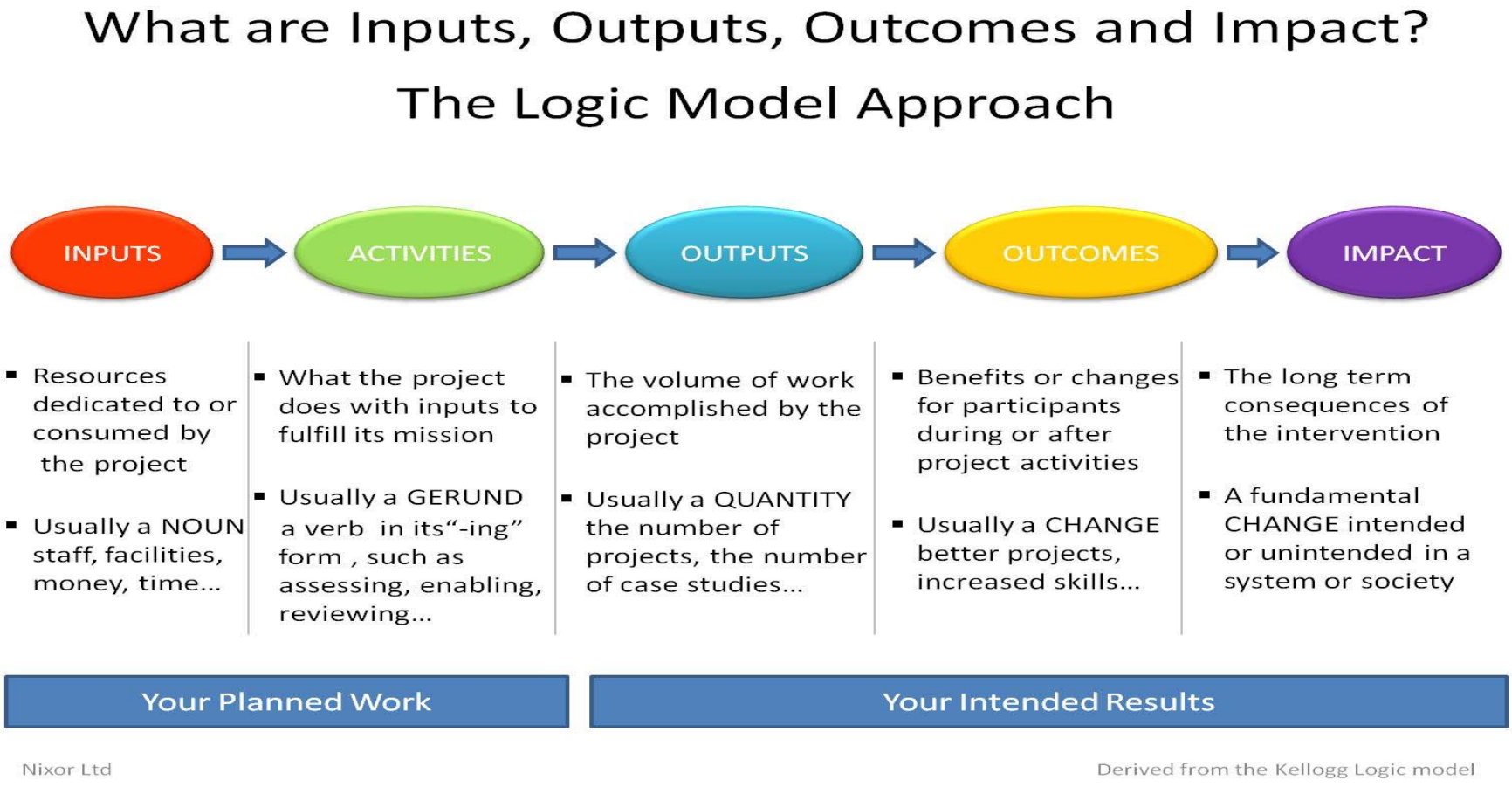
(iii) Are we achieving and will we continue to achieve strong financial performance?

	Measures of Success		
	Measure (including frequency of reporting: M, Q, S, A)	***Target***	***Progress***
Financial Performance			

Processes What critical processes do we need to put in place to enable us to achieve these key performance outcomes? How can they be improved? Are there innovative ways of achieving these outcomes better?			
Operational Excellence	***Measures of Success***		
	Measure (including frequency of reporting: M, Q, S, A)	***Target***	***Progress***

Organisational Capabilities What capabilities do we require if we are to operate and improve these processes and achieve our key performance outcomes?			
[DN: Align with selected Strategic Enablers e.g. "People"]	***Measures of Success***		
	Measure (including frequency of reporting: M, Q, S, A)	***Target***	***Progress***

Appendix 3 – Outcomes Logic Model[14]



[14] For further information on logic models see W.K. Kellogg Foundation "Logic Model Development Guide" (2006)

Appendix 4 - Measures of Success Template

This template encapsulates all the main attributes of the Measures of Success and is used to ensure that we can deliver on the measures that we have signed up to. Please complete all rows.

Name	Title of the indicator (if necessary, provide an operational definition)
Owner	Who will be responsible and accountable for this indicator?
Purpose	Why do you want to measure this?
Strategic objective	To which of the organisation's objectives does this indicator relate?
Links	What are the links between this and other indicators?
Formula	How will you measure? How will you count?
Data quality	Will there be issues in relation to the collection of data (e.g. sampling vs. complete enumeration)?
Source of data	From where will you get the necessary data?
Frequency	How often will you measure?
Target	What level of performance are you targeting?
Design process	On what basis and by whom was this target agreed?
Rewards / Penalties	If we (don't) hit the target, which rewards (penalties) will we receive (incur)?
Who measures?	Who will gather the data?
Who acts on the data?	Who will act on this indicator?
What will be done?	What action / behaviour is this target intended to promote?
Feedback	How often will you report and to whom?
Notes	Any other notes and/or comments?

The Regulation and Quality Improvement Authority

RQIA Board Meeting

Date of Meeting	11 March 2014
Title of Paper	Audit Committee Update
Agenda Item	12
Reference	H/02/14
Author	Katie Symington
Presented by	Denis Power
Purpose	The purpose of this paper is to update the RQIA Board on the recent Audit Committee meetings.
Executive Summary	The Audit Committee has met on one occasion since the last Board meeting. At the meeting on 27 February 2014, the minutes of the meeting of 24 October 2013 were approved and these are attached for noting by the Board. The Committee Chairman will verbally update the Board on the meeting of 27 February 2014.
FOI Considerations	None
Equality Impact Assessment	Not applicable
Recommendation/ Resolution	The Board is asked to **NOTE** the update from the Committee Chair.
Next steps	The Audit Committee is scheduled to meet again on 7 May 2014.

MINUTES

RQIA Audit Committee Meeting, 24 October 2013
Boardroom, 9th Floor, Riverside Tower, Belfast, 2.00pm

Present	**Officers of the Board present**
Denis Power (Chair)	Maurice Atkinson (Director of Corporate Services)
Geraldine Donaghy	Stuart Crawford (Planning and Corporate
Daniel McLarnon	Governance Manager)
Patricia O'Callaghan	Glenn Houston (Chief Executive)
Lindsey Smith	Jonathan King (Head of Finance)
Apologies	**In attendance**
Brian Clerkin, (ASM)	Catherine McKeown (Business Services
Conrad Kirkwood (DHSSPS)	Organisation, Internal Audit)
	Catherine O'Hagan (Northern Ireland Audit Office)
	Katie Symington (Board & Executive Support Manager)

1 Welcome and Apologies

1.1 The Chair welcomed all members to the Audit Committee and noted apologies from Brian Clerkin and Conrad Kirkwood.

2 Chairman's Business

2.1 The Chair of the Audit Committee noted the bi-lateral meeting held with Internal and External Audit on 19 September 2013. Key discussion focussed on the role of the Regulator post Francis, Keogh and Berwick Reports. The minute of this meeting is available for Audit Committee members.
An update was provided to the Audit Committee, by a Committee member, on the recently attended Audit Committee Chairs Forum.

2.2 The Audit Committee **NOTED** the Chairman's update.

3 Minutes of previous meeting (Paper AC/min13/June)
- **Matters Arising**
- **Notification of AOB**

3.1 The minutes of the meeting of 27 June 2013 were **APPROVED** for onward transmission to the Board on 14 November 2013.

3.2 A Committee member requested to see the Internal Audit Plan for 2013/14, as per 6.2 of the June minutes. Board and Executive Support Manager will provide a copy of this document.

A Committee member noted paragraph 2.4 of the minutes and highlighted that no feedback has been received to date on the self-assessment document. Clarification was provided that feedback on this document is not routinely provided by DHSSPS.

3.3 **Resolved Actions**
Board & Executive Support Manager to bring the amended Audit Committee minutes of the 27 June 2013 to the 14 November 2013 meeting of the Board for noting

4 Action List Review

4.1 The Chair went through the action list and noted that actions 227, 235, 236, 238, 239, 240, 241 and 242 have been completed.

4.2 The Committee noted action 237, job description for lay reviewers. The Chair advised the Committee that he and the outgoing Audit Committee Chair had provided feedback on this revised job description.

4.3 The Audit Committee **NOTED** the Action List Review**.**

4.4 **Resolved Actions**
The final job description for lay reviewers is to be shared with Audit Committee members before advertisement

Action 237 listed on the Action list will be amended to 'ongoing'

5 Update on Audit Action Plan (AC/27/13)

5.1 The Planning and Corporate Governance Manager provided an update to the Committee on the Audit Action Plan, as at 30 September 2013 and identified those which were incomplete.

The Planning and Corporate Governance Manager highlighted section 1.4, Registrations, to the Committee. The Chief Executive noted that he will discuss the delay in completion of the Registration actions with the Director of Nursing and Regulation.

The Committee noted Audit finding 21, Service Level Agreement with BSO. External Audit noted that this action is reliant on the DHSSPS.

5.2 The Audit Committee **NOTED** the update on the Audit Action Plan.

6 Internal Audit Update (AC/28/13)

- Progress Report to Audit Committee
- Mid-Year Assurance Statement from the Head of Internal Audit
- Risk Management
- Information Governance
- Finance Audit

6.1 Internal Audit presented three Audits to the Committee and noted that the additional joint RQIA/ BSO Audit on a recent recruitment exercise will be presented at the next meeting of the Audit Committee in February 2014.

6.2 Internal Audit presented the Financial Review to the Committee. No priority one weaknesses were identified and satisfactory assurance was provided by Internal Audit. All five priority two recommendations have been accepted by management.

Committee members were informed that it will not be possible to meet the prompt payment target of 95% within this financial year; however Committee members noted a marked improvement in prompt payment targets in the last few months.

6.3 Internal Audit presented the Risk Management audit. No priority one weaknesses were identified and satisfactory assurance was provided by Internal Audit. All three priority two recommendations have been accepted by management. Committee members noted that a horizon scanning process involving the RQIA Board and Executive Team was not conducted in 2013. Committee members requested that a Board workshop on Horizon Scanning be arranged before 31 March 2014.

6.4 Internal Audit presented the Information Governance audit and noted one priority one weakness, four priority two weaknesses and three priority three weaknesses. A satisfactory level of assurance was provided by Internal Audit.

Committee members noted the priority one weakness relating to low completion levels for mandatory training in relation to Information Governance and the non-identification of Information Asset Assistants. Audit Committee members noted that help should be offered to staff members to complete the elearning modules.

Confirmation was provided by the Director of Corporate Services that currently each Director is contacting those individuals who have not completed the mandatory training. A review of the mandatory training within RQIA will be undertaken to consider the frequency, means of delivery and scheduling across the year.

6.5 Internal Audit presented the Mid-Year follow up of 22 Audit recommendations and noted the implementation of 16 recommendations and the partial completion of four recommendations.
Two recommendations have not yet been implemented.

Committee members noted the priority one recommendation, implementation of new financial systems and queried the inappropriate authorisation of an invoice by a member of staff.

The Chief Executive agreed to investigate this matter.

6.6 Internal Audit presented the Mid-Year Assurance Statement, from the Head of Internal Audit, to the Audit Committee.

6.7 The Audit Committee **NOTED** the update from Internal Audit.

6.8 **Resolved Actions**
A Board workshop on Horizon Scanning to be arranged before 31 March 2014

Chief Executive to investigate the inappropriate authorisation of an invoice by a member of staff

7 External Audit Update (Verbal)

7.1 External Audit noted that following the Audit Committee meeting on 27 June 2013, it was agreed that the priority one recommendation in relation to the Service Level Agreement with BSO would be changed to a priority two recommendation. NIAO Letter in relation to the final version of the RTTCWG to be emailed to Audit Committee members.

7.2 The Audit Committee **NOTED** the External Audit update.

7.3 **Resolved Actions**
NIAO Letter in relation to the final version of the RTTCWG to be emailed to Audit Committee members

8 Update on BSTP (AC/29/13)

8.1 The Director of Corporate Services noted those documents on FPL/HRPTS which were already presented to the Committee and their identification of unresolved issues with the BSTP system.

Members noted the letters from Julie Thompson, SRO and David Bingham, BSO Chief Executive. Committee members noted the delayed receipt of this letter of assurance from BSO, dated 14 October 2013.

Committee members also noted the letter from Patrick Anderson, BSO Director of Finance, in relation to the apportionment of costs from the BSTP overspend.

Committee members noted the ongoing issues with BSTP and the impact of these issues on operational matters. It was also highlighted that the BSTP Regional Organisations Project Board has been stood down.

It was agreed that internal and external audit findings coupled with progress reports on the implementation of audit recommendations should be used as the mechanism for the Audit Committee to monitor BSTP issues. The Chief Executive will draft a response from RQIA to David Bingham. This will be shared with the Chair of Audit Committee.

Committee members asked that a response be provided to Patrick Anderson stating that RQIA will not pay the apportionment of costs in relation to the overspend on the BSTP system, as this is a Programme cost and has not been budgeted for in RQIA 2014 expenditure.

8.2 The Audit Committee **NOTED** the update on BSTP.

8.3 **Resolved Actions**
A letter of response will be provided to David Bingham

A letter of response will be provided to Patrick Anderson

9 Report on Data Security Incident (4 September 2013) (AC/30/13)

9.1 The Chief Executive provided an update to Committee members on the data security incident, which occurred on 4 September 2013.
This incident has been reported to the Information Commissioners Office and is also detailed within the Information Governance Internal Audit report.

Committee members acknowledged that whilst no data loss had been incurred, the transfer of un-encrypted data and failure to complete mandatory training were lessons to be learned from this incident. Committee members acknowledged that the incident had been escalated to Senior Management and dealt with in an appropriate manner. The Chief Executive outlined the eight recommendations in the report and indicated that their implementation will be closely monitored by the Executive Management Team.

Committee members requested assurances that the new RISCP system will provide safeguards in relation to the secure management of sensitive, personal, identifiable information. The Chief Executive will confirm the functionality of the RISCP system and report to Committee members accordingly.

9.2 Confirmation was provided to members that progress in implementing the eight recommendations detailed in the Report on the Data Security Incident will be presented at a future Audit Committee meeting.

Committee members were also informed that at RQIA's request the ICO will conduct an advisory visit to RQIA.

9.3 The Chief Executive noted that he will meet with the appropriate RQIA Director on Monday 28 October and their team members to impress the importance of this issue.

The Head of Information and ICT Manager will also be requested to present at the next staff meeting to raise awareness levels for all staff members.

9.4 The Audit Committee **NOTED** the Report on the Data Security Incident, 4 September 2013.

9.5 **Resolved Actions**

The Chief Executive will provide an update to Committee members on the functionality of the RISCP system to protect sensitive, personal, identifiable information

The Chief Executive will meet with the appropriate Director and team members to discuss the data security incident

The Head of Information and ICT Manager will provide a presentation to all staff at the next staff meeting

10 RQIA Mid-Year Assurance Statement (AC/31/13)

10.1 The Director of Corporate Services presented the Mid-Year Assurance Statement to Committee members. A draft version of this document has been sent to DHSSPS. Any amendments requested by the Audit Committee will be forwarded onto DHSSPS for inclusion.

10.2 The Audit Committee Chair requested the inclusion of Horizon Scanning to point 3, Risk Register. Agreement that the date the Mid-Year Progress Report was sent to DHSSPS should be included within Point 8, Performance against Departmental Priorities.
A Committee member requested that the bullet points within point 9, Internal Control Divergences, should read 'all staff **will**' and not 'should'.

10.3 Internal Audit requested that the reference to Internal Audit providing Mid-Year assurance is removed from point 10, as this is currently not provided by Internal Audit.

10.4 Confirmation was provided that the final version of the Mid-Year Assurance statement will be shared with the Chair of Audit Committee before it is sent to DHSSPS.

10.5 The Audit Committee **APPROVED** the RQIA Mid-Year Assurance Statement, with changes.

10.6 **Resolved Actions**

The Mid-Year Assurance Statement will be amended to reflect the requested changes by the Audit Committee

The amended Assurance Statement will be shared with the Chair of the Audit Committee before it is sent to DHSSPS

11 Review of Controls Assurance Standards (AC/32/13)

11.1 The Planning and Corporate Governance Manager presented the Review of two Controls Assurance Standards to the Committee.

Confirmation was provided to the Committee that following further review of these standards, they are not currently relevant to RQIA and no further benefit is identified from the adoption of these additional Controls Assurance Standards.

11.2 The Audit Committee **APPROVED** the Review of Controls Assurance Standards.

12 Review of Standing Orders (AC/33/13)
Audit Committee Terms of Reference

12.1 The Director of Corporate Services presented the review of Standing Orders to the Audit Committee. It was noted that Standing Orders are reviewed and changes approved annually, first by the Audit Committee and then by the Board.

Two changes are noted to the Standing Orders; addition of Part II Doctors to Standing Order five and a change to section 3.4.1.2 in relation to procedures for decision making panels.

The Audit Committee confirmed that as the addition to Standing Order five, Part II Doctors, was agreed at the September Board meeting, it does not need to go to the November Board meeting for approval.

Committee members agreed that no changes were required to the Audit Committee Terms of Reference.

12.2 The Audit Committee **APPROVED** the Review of Standing Orders.

12.3 **<u>Resolved Actions</u>**
The Review of Standing Orders will be presented at the November Board meeting

13 Review of RQIA's Assurance Framework arrangements (DR) (AC/34/13)

13.1 The Planning and Corporate Governance Manager presented the Review of RQIA's Assurance Framework arrangements.

13.2 The Audit Committee **NOTED** the Review of RQIA's Assurance Framework arrangements.

14 Review of the systems to implement relevant action plans (DR) (AC/35/13)

14.1 The Planning and Corporate Governance Manager presented the Review of the systems to implement relevant action plans.

Committee members noted the review of systems and requested an amendment to 'Action Plans from External Organisations'.

Internal Audit also requested an amendment to the flowchart on page one, should recommendations not be accepted by management, this information should be referred back to the Audit Committee.

The Audit Committee **NOTED** the Review of the systems to implement relevant action plans.

14.2 The Chair drew member's attention to the recent Northern Ireland Fire and Rescue Service Report, from the Public Accounts Committee (PAC). Printed copies of the Executive Report are available for Committee members, a link to this document will also be shared with Committee members. This item will also be added to the agenda of the next Audit Committee meeting.

The Chair also noted the amended date for the October Audit Committee meeting, 2014 and noted that all committee meetings in 2014 will commence at 11:00.

14.3 **Resolved Actions**

Changes will be made as requested to the paragraph, 'Action Plans from External Organisations' and also to the flowchart on page 1

Link to the PAC Report to be sent to members of the Audit Committee

PAC Report to be added to the agenda of the next Audit Committee meeting

All committee members to be circulated the new date for the October 2014 Audit Committee meeting

15 Single Tender Actions & External Consultancy (AC/36/13)

15.1 The Head of Finance confirmed that no external consultancy engagements occurred during quarter two of 2013/14 financial year and therefore no external consultancy engagements have occurred within the 2013/14 financial year to date.

15.2 The Head of Finance confirmed that no new Single Tender Actions occurred in quarter two of the 2013/14 financial year. Therefore only one Single Tender Action has occurred in the 2013/14 financial year to date.

15.3 The Audit Committee **NOTED** the update on Single Tender Actions & External Consultancy.

16 Update on DHSSPS Circulars (AC/37/13)

16.1 The Head of Finance noted two DHSSPS circulars in relation to fraud.

16.2 The Audit Committee **NOTED** the update on DHSSPS Circulars.

17 Any Other Business

17.1 As there was no other business the Chairman brought the meeting of the Audit Committee to a close.

Date of next meeting: Thursday 27 February 2014, 2.00, Boardroom, RQIA

ACTION LIST

RQIA Audit Committee Meeting 24 October 2013

Action	Minutes Ref	Description	Assigned to	Date Due	Status
233	June 13 (Para 2.7)	Correspondence received by RQIA in relation to BSTP to be shared at the next Audit Committee meeting	Chief Executive	October 13	Complete
234	June 13 (Para 2.7)	An update on the BSTP Critical Action Plan is to be shared at the next Audit Committee meeting	Director of Corporate Services	October 13	Complete
237	June 13 (Para 3.5) & Oct 13 (Para 4.4)	The final Job description for lay reviewers and guiding principles for professional reviewers to be shared with the Audit Committee	Chief Executive	October 13	Complete
243	Oct 13 (Para 3.3)	Board & Executive Support Manager to bring amended Audit Committee minutes of the 27 June 2013 to the 14 November 2013 meeting of the Board for noting	Board & Executive Support Manager	November 2013	Complete
244	Oct 13 (Para 4.4)	Action 237 listed on the Action list will be amended to ongoing	Board & Executive Support Manager	October 2013	Complete
245	Oct 13 (Para 6.8)	A Board workshop on Horizon Scanning to be arranged before 31 March 2014	Chief Executive	November 2013	Complete
246	Oct 13 (Para 6.8)	Chief Executive to investigate the improper authorisation of an invoice by a member of staff	Chief Executive	February 2014	Ongoing

Action	Minutes Ref	Description	Assigned to	Date Due	Status
247	Oct 13 (Para 7.3)	NIAO Letter in relation to the final version of the RTTCWG to be emailed to Audit Committee members	Board and Executive Support Manager	February 2014	Complete
248	Oct 13 (Para 8.3)	A letter of response will be provided to David Bingham	Director of Corporate Services	October 2013	Complete
249	Oct 13 (Para 8.3)	A letter of response will be provided to Patrick Anderson	Director of Corporate Services	October 2013	Complete
250	Oct 13 (Para 9.5)	The Chief Executive will provide an update to Committee members on the functionality of the RISCP system to protect sensitive, personal, identifiable information	Chief Executive	February 2014	Ongoing
251	Oct 13 (Para 9.5)	The Chief Executive will meet with the appropriate Director and team members to discuss the data security incident	Chief Executive	October 2013	Complete
252	Oct 13 (Para 9.5)	The Head of Information and ICT Manager will provide a presentation to all staff at the next staff meeting	Chief Executive	November 2013	Complete
253	Oct 13 (Para 10.6)	The Mid-Year Assurance Statement will be amended to reflect the requested changes by the Audit Committee	Planning and Corporate Governance Manager	October 2013	Complete
254	Oct 13 (Para 10.6)	The amended Assurance Statement will be shared with the Chair of the Audit Committee before it is sent to DHSSPS	Board and Executive Support Manager	October 2013	Complete

Action	Minutes Ref	Description	Assigned to	Date Due	Status
255	Oct 13 (Para 12.3)	The Review of Standing Orders will be presented at the November Board meeting	Board and Executive Support Manager	November 2013	Complete
256	Oct 13 (Para 14.3)	Changes will be made as requested to the paragraph, 'Action Plans from External Organisations', and to the flowchart, within the 'Review of the systems to implement relevant action plans'	Planning and Corporate Governance Manager	October 2013	Complete
257	Oct 13 (Para 14.3)	Link to the PAC Report to be sent to members of the Audit Committee	Board and Executive Support Manager	October 2013	Complete
258	Oct 13 (Para 14.3)	PAC Report (NIFRS) to be added to the agenda of the next Audit Committee meeting	Board and Executive Support Manager	February 2014	Complete
259	Oct 13 (Para 14.3)	All committee members to be circulated the new date for the October 2014 Audit Committee meeting	Board and Executive Support Manager	October 2013	Complete

The Regulation and Quality Improvement Authority

RQIA Board Meeting

Date of Meeting	11 March 2014
Title of Paper	Board Governance self-assessment tool and Case Study
Agenda Item	13
Reference	I/02/14
Author	-
Presented by	Dr Ian Carson
Purpose	To present the completed Board Governance self-assessment tool and Case Study to Board members for **APPROVAL** before submission to DHSSPS.
Executive Summary	Board member comments are detailed from pages 39-79.
FOI Exemptions Applied	None
Equality Impact Assessment	Not applicable
Recommendation/ Resolution	It is recommended that the Board should **APPROVE** the Board Governance self-assessment tool.
Next steps	The completed Board self-assessment tool will be returned to DHSSPS.

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

BOARD GOVERNANCE SELF ASSESSMENT TOOL

For use by DHSSPS Sponsored Arms Length Bodies

Updated 21st October 2013

Contents

1.Board Composition and Commitment

2. Board evaluation, development and learning

3. Board Insight and foresight

4. Board Engagement and Involvement

5. Self Assessment Submission.....38

6. Board Impact Case Studies

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 CIPFA). Good governance is not judged by 'nothing going wrong'. Even in the best boards and organisations bad things happen and board effectiveness is demonstrated by the appropriateness of the response when difficulties arise.

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

This checklist has been developed by reviewing various governance tools already in use across the UK and the structure and format is based primarily on Department of Health governance tools. The checklist does not impose any new governance requirements on DHSSPS 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, Social Services and Public Safety (DHSSPS).

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.

Report produced: The ALB Board should provide a report back to Department's Central ALB Governance Unit (CAGU). This report should include the self-assessment ratings reached by the ALB Board and, where necessary, provide details on action plans on how they are going to comply with best practice.

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 and subsequently to the Department. This report will include their independent view on the accuracy of the Board's ratings and where necessary, provide recommendations for improvement. The Department may also wish to explore options at its disposal to ask for its own independent verification.

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 (pg 10-37) using the electronic Submission Document (pg 39-60). 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 (pg 61-62) which includes identifying areas where additional training/guidance and/or assurance is required.

Step 2

In addition to the RAG rating and evidence described above, the Board is required to complete 3 mini case studies (pg 65-68) on;

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

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

Step 3

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

Scoring Criteria

The scoring criteria for each section is as follows:

Green if the following applies:

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

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

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

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

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

Red if the following applies:

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

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

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

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

The Report

The ALB will provide a summary report (see proforma) to the Department which will comprise of:

1. the self-assessment ratings reached by the ALB Board;
2. a brief description of the action plans that will be implemented to ensure compliance with Best Practice;
3. areas where the Board believes additional assurance is required; and
4. their feedback on the self-assessment and any suggested areas for improvement (e.g. identify specific criteria that need tweaked).

Replies to:

Central Arm's Length Bodies Governance Unit

Room D1.1

Castle Building

Stormont

BT4 3SQ

1. Board composition and commitment

1. Board composition and commitment overview

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

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

1. Board composition and commitment

1.1 Board positions and size

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

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

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 2 years by a 3rd party that has a good track record in undertaking Board effectiveness evaluations. 4. In undertaking its self assessment, the Board has used an approach that includes various evaluation methods. In particular, the Board has considered the perspective of a representative sample of staff and key external stakeholders (e.g. commissioners, service users and clients) on whether or not they perceive the Board to be effective. 5. The focus of the self assessment included traditional 'hard' (e.g. Board information, governance structure) and 'soft' dimensions of effectiveness. In the case of the latter, the evaluation considered as a minimum: • The knowledge, experience and skills required to effectively govern the organisation and whether or not the Board's membership currently has this; • How effectively meetings of the Board are chaired; • The effectiveness of challenge provided by Board members; • Role clarity between the Chair and CE, Executive Directors and NEDs, between the Board and management and between the Board and its various committees; • Whether the Board's agenda is appropriately balanced between: strategy and current performance; finance and quality; making decisions and noting/ receiving information; matters internal to the organisation and external considerations; and business conducted at public board meetings and that done in confidential session. • The quality of relationships between Board members, including the Chair and CE. In particular, whether or not any one Board member has a tendency to dominate Board discussions and the level of mutual trust and respect between members.

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

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

3. Board insight and foresight

3.5 Assurance and risk management

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

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.	• 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

5. Board Governance Self- Assessment Submission

Name of ALB: RQIA

Date of Board Meeting at which Submission was discussed: 11 March 2014

Approved by: …….....(ALB Chair)

1. Board composition and commitment ALB Name: RQIA Date: 11 March 2014

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.			Legal advice to Board from DLS in areas of potential conflict.
GP3	See Standing Orders			
GP4	See Standing Orders	Appointment letters to Board Committees.		
GP5		New Board members are now being appointed.	Four of the current 12 Board members are due to end their second terms of office on 28 February 2014. The tenure of Board members is not within the responsibility of the Board of RQIA.	

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1		Not applicable
RF2	One vacancy for eight months.	
RF3		Not applicable

1. Board composition and commitment ALB Name: RQIA Date: 11 March 2014

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	Annual report considered by Board on Equality Responsibilities and website.			
GP4	Descriptions of interests and background of Board members set out in Annual Reports and website.	A lay Board with specific skills in this area are required.		
GP5	Descriptions of interests and background of Board members set out in Annual Reports and website, including members with both legal and financial expertise. New Board members being appointed with relevant technical and professional			

	expertise.			
GP6			The tenure of Board members is not within the responsibility of the Board of RQIA.	
GP7	Board member profiles are contained with RQIA annual reports.			
GP8	Descriptions of interests and background of Board members set out in Annual Reports and website.		The current Chair has led the organisation for seven and a half years and is due to retire at the end of May 2014.	
GP9			The Chair of the Board had significant Executive experience as a Board member of a large complex organisation although not as a Non-Executive. He was also a Senior Civil Servant.	
GP10	Descriptions of interests and background of Board members set out in Annual Reports and website. The Chair of the Audit Committee is financially qualified.			

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1		Not applicable
RF2		Not applicable
RF3		Not applicable

RF4		Not applicable
RF5		All Board members are Non Executive in keeping with statutes establishing the organisation
RF6		Not applicable

1. Board composition and commitment ALB Name: RQIA Date: 11 March 2014

1.3 Role of the Board

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1	1.Standing Orders 2. Recruitment documentation 3. Copies of material and presentations at Board member induction events.			
GP2	Board Corporate Strategy 2012/15 & Three Year Review programme have been approved by the Department.			
GP3	Standing Orders. All Board members are Non-Executive in keeping with statutory requirements.			
GP4	Minutes of Board meetings. Quarterly review of Performance Framework.			
GP5	Minutes of Board meetings - demonstrated Board members independence and bring			

	challenge. All Board members are Non-Executive in keeping with statutory requirements.			
GP6	Minutes of Accountability Review meetings. 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. EFQM Assessment Report.			
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 in discussion for this report.			
GP15	Board Minutes Consultations when preparing Corporate Strategy and 3 Year Review Programme for 2012-2015.			
GP16	Standing orders reviewed on 14 November 2013 and 16 January 2014.			
GP17	Corporate Performance Reports on progress on major programmes of work. Annual reports on programmes including Hygiene Inspections, Regulation and Mental Health Work. NB Role of Audit Committee Cross ref 3.5.		RQIA has few major IT or capital projects which would result in formal post- evaluation reviews. A review will be carried out following the implementation of the i-Connect system to support regulation functions.	

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1		Not applicable
RF2		Not applicable
RF3		Not applicable
RF4		Not applicable
RF5		Not applicable

RF6		Not applicable

1. Board composition and commitment ALB Name: RQIA Date: 11 March 2014

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			
GP4	Standing Orders Minutes of Board meetings			
GP5	Standing Orders Minutes of Board meetings			
GP6	Standing Orders Minutes of Board meetings Minutes of Audit Committee Minutes of Appointment and Remuneration Committee			
GP7	Annual assurance statement provided to Board and validated by External Auditors NIAO RQIA audit committee carries out an annual self assessment which is submitted to DHSSPS.		Appointments and Remuneration Committee is properly structured and reports to Board after meetings, but is not externally evaluated.	

GP8	Board minutes; Committee 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		Not applicable – (Evidence Board minutes)
RF2		Discussed at annual appraisals with Chair
RF3		Not applicable
RF4		Not applicable
RF5		Not applicable

1. Board composition and commitment ALB Name: RQIA Date: 11 March 2014

1.5 Board member commitment

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1	Board and Committee attendance lists for past year.			
GP2	Input to committees and short life working groups discussed at Board meetings and formal process adopted. Example – Board paper on input to review programme.	Formal letter of appointment Terms of reference of Committee Appraisal of Board members		
GP3	Standing Order 6 and incorporated into Induction Programme.			
GP4	Schedule of meetings for 2014.			

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1		Not applicable
RF2		Not applicable – Board & Committee attendance lists
RF3		Not applicable – Board & Committee attendance lists

RF4		Not applicable
		Not applicable – Board & Committee attendance lists

2. Board evaluation, development and learning ALB Name: RQIA Date: 11 March 2014

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 DHSSPS, with Permanent Secretary, twice a year.	DHSSP Board Governance Self Assessment Tool.	Not applicable	
GP2	Formal evaluation of Audit Committee.	Short life working groups with Board members engaged in work appropriate to their base.	Not applicable	Planned rotation of committee membership
GP3	DHSSPS to provide direction on identification of relevant 3rd party regional evaluation protocol for ALB's to promote consistency and facilitate benchmarking.	Proposal to contract external evaluation to be drafted.	New requirement	
GP4	Board worked in setting strategic direction.	For board to be developed.	New requirement	• Board action plan to be drafted • Peer review of Board effectiveness
GP5	Board Standing Orders (Nov. 2012) and Management Statement and Financial Memorandum (September 2010) in place and fully operational.	All Board meetings are open to the public. Board and Committee minutes formally approved by RQIA Board and made available on RQIA website.		Consideration to 'paperlite' Board meetings currently under review.

	Board Standing Orders revised and updated 2013. Board secretariat received and additional capacity identified.	Action list included with minutes of future Board meetings.		

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	Board member to take the lead and develop a Board effectiveness Programme.	
RF2	Evaluation protocol to be drafted, following after discussion with DHSSPS.	Board evaluation should not be constrained by a specific tool.
RF3	External perspectives to be considered. 360 degree feedback to be explored.	Stakeholder mapping to be undertaken by Board Members.
RF4	Mixed methodologies to be included in evaluation. Board to engage Investors in People.	

2. Board evaluation, development and learning ALB Name: RQIA Date: 11 March 2014

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.	CPD programme based on competency assessment. Board development programme to be outlined.		Evidence based framework for ongoing CPD based on skills evaluation approach would support identification of individual and team learning needs analysis, linked to a structured Board development plan.
GP2	Regular engagement with Minister and DHSSPS.	Planned programme of meetings with key partners. There is a need to develop a 'Board Message' in order to maximise the potential Board Members to act as ambassadors.		
GP3	Corporate Strategy map Risk Management framework.	Proactive management of areas of identified risk e.g. consent enforcement, patient and Public working.		
GP4	Regular board workshops scheduled bi-monthly.	Additional enhanced programme of Board development activities required.	Capacity and resource issues to deliver a Board development programme.	

GP5	Board workshops consistently achieve 90% attendance targeted workshops have been undertaken on 'hot topics' Part IV doctors, Enforcement Safe Guarding.	Additional training would require greater commitment.		
GP6	Planned programme of activities linked to Business Plan.	As per GP4		

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	Discussion with sponsor branch on how to meet CPD requirements. Board Member to take the lead and develop a Board effective programme. There is a need to consider formal Board development days. 2 per year.	
RF2	There is potential to learn from how the Boards of other system regulators operate. Links with our equivalent body in Scotland should be explored.	

2. Board evaluation, development and learning ALB Name: RQIA Date: 11 March 2014

2.3 Board induction, succession and contingency planning

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1	Formal induction of newly appointed Board members undertaken.			Induction reviewed in light of feedback and consideration of mentoring programme for new Board members.
GP2	Specified timeline for induction including CIPFA induction includes potential for visits with inspectors.		To note that delays in appointments of Board Members Impacts on the ability to undertake timely induction.	Induction linked to competence framework as per 2.2.
GP3	See GP1 above.			
GP4	Deputising arrangements within Standing Orders (Standing Order 4).	Impact of new Board Members in committee function to be reviewed		
GP5	2013 appointments of Board members identified a requirement for specific skill sets e.g. Finance, Nursing, Medical etc.	Identification of skills and competencies of effective Boards will assist in future success in planning. Skills of communication and Public relations management to be considered.		Skill sets will require evaluation.

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1		
RF2		
RF3		
RF4	The of appointment of Board Members requires further consideration to achieve a better distribution of terms of appointments, as the Board will lose 9 of its 12 members in two tranches during April and September 2013. Delays in appointments of new Board Members has introduced a significant but preventable risk.	

2. Board evaluation, development and learning ALB Name: RQIA Date: 11 March 2014

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.		
GP2	All Board members are Non Executive in keeping with statutes establishing the organisation.			
GP3	Appraisal process undertaken as set by Permanent Secretary.			
GP4	Board member objectives linked to Business Plan.			
GP5	PDP developed for each Board Member.			
GP6	Board Members contribution to committees, panels and stakeholders involvement is noted.			
GP7	Professional CPD requirements met in full.			

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	360 degree feedback for Board members to be considered.	
RF2		
RF3		
RF4		

3. Board insight and foresight ALB Name: RQIA Date: 11 March 2014

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.			
GP3	Chairs of both Audit Committee and Remuneration Committee report to the Board. Updates are also provided from Chairs of Panels and Short-Life Working Groups 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. Horizon scanning of Risk landscape is undertaken annually at a Board workshop in conjunction with Executive Management Team. Regular briefings to Board are provided by Chief Executive, Director of Corporate Services and Chair			

	of Audit Committee.			
GP5	Action log is available as part of 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	n/a	
RF2	n/a	
RF3	n/a	
RF4	n/a	
RF5	n/a	

3. Board insight and foresight ALB Name: RQIA Date: 11 March 2014

3.2 Efficiency and Productivity

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1	Corporate Risk Assurance Framework Report presented and discussed at the Audit Committee and at Board meetings quarterly. Process exists to escalate specific risks to Departmental level as necessary. Board have an annual workshop to review key risks and plan to manage risks is agreed.			
GP2	The Board approves an improvement and efficiency plan.			
GP3	Improvement and Efficiency Plan are incorporated into Corporate Performance Report which is Rag Rated.			
GP4	The progress of service delivery plan is included in the Corporate Performance Report and the Board reviews and			

	approves Integrated Risk Assurance Framework Report and Corporate Risk Register information in the Corporate Risk Assurance Framework 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	n/a	
RF2	n/a	
RF3	n/a	
RF4	n/a	

3. Board insight and foresight ALB Name: RQIA Date: 11 March 2014

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 provides a report to each meeting of the Board which addresses strategic issues impacting upon the work of the organisation.			
GP2	Key learning is derived from Audit reports, Adverse incidents, and the outcome of enforcement review panels. RQIA will continue to use Board workshops to consider the learning from significant events and inquiries including, for example, the Francis Report of Mid Staffordshire NHS Trust, NIAO Reports, Reports of Public Accounts Committee etc. RQIA Board receives regular reports at Board meetings of enforcement actions taken in respect of registered agencies and establishments. RQIA Board members engaged in training in their role as			

	members of Enforcement Review and Decision making panels (ref. RQIA Enforcement Policy and Procedures).			
GP3	The Executive Management Team in collaboration with staff prepare a draft Business Plan. The Board provide feedback and contribute to the final draft of the Business Plan prior to formal approval at a Board meeting. Annual Business plan for 2013-14 was brought to and approved at the January 2014 Board meeting.			
GP4	The key performance indicators set out in the Business plan are monitored by the Board through the Corporate Performance Report.			
GP5	The Corporate Risk Assurance Framework report is approved by the Board in consultation with the Executive Management Team.			

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

RF3	n/a	

3. Board insight and foresight ALB Name: RQIA Date: 11 March 2014

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. 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. Chief Executive updates Chairman, 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. Internal Audit is scheduled to conduct a review of the timeliness, completeness, quality and accuracy of performance data being presented to the Board in Qtr 3 2013/14.			
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	n/a	
RF2	n/a	
RF3	n/a	
RF4	n/a	
RF5	n/a	

3. Board insight and foresight ALB Name: RQIA Date: 11 March 2014

3.5 Assurance and risk management

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1	Format of Corporate Risk Assurance Framework and Risk Register as agreed by Board has been fully implemented to identify, assess and manage risks in RQIA.	A Business case for an additional Financial Inspector has been submitted to DHSSPS for approval.		Insufficient assurances have been provided in respect of availability of financial inspectors to identify risk in sector.
GP2	The Corporate Risk Assurance Framework provides information and assurance on the management of key risks in RQIA.			
GP3	Internal audits and external audit by NIAO of controls assurance standards in RQIA are undertaken and shared with Board and Audit Committee.			
GP4	The Good Governance Standards for Public Services has been provided to all Board members. Newly appointed Board members have attended training on Good Governance provided by CIPFA.			Newly appointed Board members in 2014 to attend CIPFA training on Good Governance.

	In 2013 new members of the Board and Audit Committee attended appropriate training.			
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	A Business case for an additional Financial Inspector has been submitted to DHSSPS for approval.	Awaiting DHSSPS approval of business case.
RF2		
RF3		
RF4		

4. Board engagement and involvement ALB Name: RQIA Date: 11 March 2014

4.1 External stakeholders

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1	Have a PPI Strategy, PPI Forum and action plan.			
GP2	Recruitment of lay reviewers in Mental Health and in Review Programme. Consultation with advocacy groups in Mental Health and Learning Disability. Easy read versions of inspection reports are now being prepared by MHLD staff and will be available following every inspection from 1 April 2014. The views of the Tilli Group have been taken into consideration in the development of easy read reports from the Mental Health and Learning Disability Team.			
GP3	RQIA hold roadshows and workshops to advise the HSCB Board, the Regulated sector and Mental Health and Learning Disability sector of the business plan for the 2014/ 2015 Regulation and Mental Health and Learning Disability			

	programme of care.			
GP4	MHLD programme hosted a workshop for all Part II /Part IV Doctors to ensure that they understood the requirements to be appointed by the RQIA Board and the process to follow to seek appointment. RQIA held a workshop to review the findings of the Francis Report in relation to the sharing of information, 24 October 2013.			
GP5	RQIA Board responded to a data incident which involved ICT training of all staff and with a 100% of compliance achieved.			
GP6	RQIA meet with DHSSPS monthly (liaison meetings) and with PHA/ Trust/ PCC, six monthly and with all of the other members of National Preventative Mechanism. Minutes are available for these meetings.			

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

RF3	n/a	
RF4	n/a	
RF5	n/a	

4. Board engagement and involvement ALB Name: RQIA Date: 11 March 2014

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 development workshop was held on 25 April 2013 to plan for the development of a Culture Charter, which was subsequently launched on 10 October 2013. Staff are also advised of developments by use of Intranet, staff e-zine magazine and through teleconference facilities to Omagh office. The staff survey is ongoing at present.			
GP2	The Director of Corporate Services has held meetings with all of the teams in RQIA to seek their views on the development on the 2015-18 Corporate Strategy. Records of these meetings are available.			
GP3				
GP4	The Board enjoined in the celebration of the EFQM award for the RQIA. A Human Resources and			

	Organisational Development Strategy was approved by the Board for use in 2013 and has been shared with all staff members.			
GP5	RQIA have developed a Culture Charter which was launched in October 2013. RQIA has a suite of policies and procedures available on the intranet for all staff members.			
GP6	RQIA Board responded to a data incident which involved ICT training of all staff and with a 100% of compliance achieved.			

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

4. Board engagement and involvement ALB Name: RQIA Date: 11 March 2014

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	All new staff and Board members receive a robust induction process. The Corporate Risk Assurance Framework Report is brought to the Board for approval four times a year. Each directorate has a risk register which is updated monthly at team meetings. 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	Yearly Board members will attend, for example, the NICON Conference to increase their profile and their learning regarding key strategic issues. The Chair and Chief Executive regularly meet with other regulators, for example Healthcare Inspectorate Scotland. In addition the Chair			

	and Chief Executive attend breakfast meetings at the Beeches Management Centre.			
GP3	Board members attended the workshop for Part II/ Part IV Doctors, hosted by the MHLD Team.			
GP4				
GP5	Minutes of RQIA Board meetings are available on the RQIA website.			
GP6				

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

Summary Results **ALB Name: RQIA** **Date: 11 March 2014**

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

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

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

3.5 Assurance and risk management		

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

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

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

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

6. Board impact case studies

6. Board impact case studies

Overview

This section focuses on the impact that the Board is having on the ALB and considers recent case studies in the following areas:

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

2. Organisational culture change; and

3. Organisational strategy.

6. Board impact case studies

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

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

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

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

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

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

6. Board impact case studies ALB Name.....Date.....

6.1 Case Study 1

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

6. Board impact case studies ALB Name.....Date.....

6.2 Case Study 2

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

6. Board impact case studies ALB Name.....Date.....

6.3 Case Study 3

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

6.3 Case Study 3

Organisational strategy	**Title: RQIA Corporate Strategy 2012/15**
Brief description of area of focus	This case study describes the ongoing leadership provided by the Board in collaboration with the Executive Management Team in shaping the organisation's strategic direction and overseeing the effective implementation and review of RQIA's Corporate Strategy 2012/15.
Outline reasons / rationale for why the Board wanted to focus on this area	One of the critical roles of the Board is to set and continually review the strategic direction of the organisation as well as ensuring that the strategy is being effectively translated into action.
Outline how the Board was assured that the plan/ (s) in place were robust and realistic	The Board was fully involved in the development of the 2012/15 Strategy. This included the establishment of a Strategy Steering Group consisting of 3 Board members and the Executive Team, engagement with staff and key stakeholders, formal consultation on the Strategy, regular updates to the Board at Workshops and Board meetings during the development of the Strategy and formal approval of the Strategy by the Board. A similar process is being followed for the development of the 2015/18 Strategy.
Outline the assurances received by the Board that the plan/(s) were implemented and delivered the desired changes in culture	RQIA has a Performance Management Framework (PMF) in place which sets out the organisation's approach to strategic performance management. This means that the Corporate Strategy is translated into an annual Business Plan, a suite of Measures of Success (MoS) have been developed and reviewed (2013), strategic

Organisational strategy	**Title: RQIA Corporate Strategy 2012/15**
	risks are identified and managed and a Corporate Performance Report is presented for consideration by the Board on a quarterly basis. This report provides a progress update on the delivery of actions in the Business Plan and uses Headlines, a traffic lights system and exception reporting.
Specifically explain how the NEDs were involved	Members of the Board are fully involved in the development, approval and review of the Corporate Strategy, approval of associated Business Plans, risk identification and mitigation and consideration/challenge of progress in the delivery of the Corporate Strategy. See also response to Point 3 above – "*Outline how the Board was assured that the plan/ (s) in place were robust and realistic*" – which outlines the involvement of Board members in, for example, the Strategy Steering Group, Workshops, pre-consultation roadshows and Board meetings.