

# ANNUAL REPORT 2020



**Health  
Information  
and Quality  
Authority**

An tÚdarás Um Fhaisnéis  
agus Cálíocht Sláinte

*Safer Better Care*



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# Foreword from the Chairman



**Professor Pat O'Mahony,**  
Chairman


**2020 has been a year like no other in living memory, and HIQA's 2020 Annual Report is reflective of that. This has been a very difficult year for many. On behalf of HIQA, I offer my deepest sympathies to all those who lost a loved one to COVID-19.**

I would like to thank all our staff for their hard work and commitment in stepping up to new challenges in 2020, on top of ensuring we fulfilled our objectives during the year. I commend them for being flexible and working above and beyond at a time of national crisis. I would also like to acknowledge the tireless work and contributions of health and care staff right across Ireland's health and social care system for their efforts in the national response to the pandemic.

While continuing to fulfil our remit and meet our business plan objectives, we responded decisively to the pandemic, using our powers, resources and expert knowledge to contribute to the national and international fight against the disease. Represented on the National Public Health Emergency Team (NPHE) and its subgroups, we engaged with Government and public health from the outset of the public health emergency. Throughout the year, we liaised and worked closely with our stakeholders to ensure a cohesive approach to tackling many of the challenges posed by COVID-19.

As the body with responsibility for conducting health technology assessments to inform national policy and health service decisions in Ireland, we advanced knowledge about the emerging virus. Our evidence synthesis work provided advice to decision-makers on how COVID-19 could be better identified, tracked and traced, and how to better protect our vulnerable populations. We established a multidisciplinary COVID-19 Expert Advisory Group to provide expert input on our evidence synthesis work, and developed advice for NPHE.

As the regulator, we continued to monitor the safety and quality of health and social care services, responding to risk and liaising with the Health Service Executive (HSE) to better assist those services that needed support. We have become all too familiar with the impact of COVID-19 in nursing homes in particular, and we are committed to continuing to highlight changes required at legislative and policy level to protect our vulnerable populations.



As part of our monitoring activities in healthcare services, we conducted a desktop infection prevention and control risk assessment exercise at the request of NPHE, which was used to assist its decision-making around risk and additional supports to be provided to acute hospitals in this area. We also adapted this self-assessment tool to aid the HSE to conduct its own subsequent assessments in private hospitals. As the impact of COVID-19 became clearer through the year, we noted shortcomings in the regulatory framework for social care services available to us. While reform of the framework has been something we have called for previously, as Chairperson I wrote to the Minister seeking short and longer term reforms to the legislation aimed at providing better protections to some of our more vulnerable populations in receipt of care. We are now working with the Department of Health to effect some of these reforms.

We also contributed to national efforts through contact tracing, redeploying staff to other health bodies, and developing supports for the wider sector. For example, we established the Infection Prevention and Control Hub to support designated centres, and launched a new elearning module on infection prevention and control to support and upskill health and social care staff. This programme has been accessed by over 16,000 people, the majority of whom work in a health or social care service.

HIQA aims to improve the quality of health and social care in Ireland. During 2020, we continued this work across a number of areas including through promoting adult safeguarding in services, and commencing the development of new national standards to improve children's experiences in services.

At the beginning of the year, we published our findings from inspections of maternity units and hospitals across the country, outlining a number of recommendations for improving maternity care for the women of Ireland. In October, we saw the results of Ireland's first National Maternity Experience Survey, with 85% of new mothers describing their overall experience of care as good or very good. Significantly, women highlighted areas for improvement and we continue to work alongside the HSE and Department of Health in this regard.

2020 further highlighted the need for developments in our health information policies, systems and legislation. Dealing with key issues such as contact tracing and vaccination rollout places a spotlight on the need for key eHealth elements contained within the Sláintecare strategy. We developed recommendations on implementing a national electronic patient summary for the Minister for Health and conducted a survey of the Irish public's views on the collection, use and sharing of their health information. These are important steps in rolling out eHealth in Ireland, and we will progress this key work in the area of information modelling in 2021.

Looking forward, COVID-19 will remain a challenge for the health and social care sector for the coming years. We will work to progress the implementation of recommendations of the COVID-19 Nursing Home Expert Panel. We will also prepare to take on new responsibilities and commitments that have been set out in the Programme for Government and elsewhere, including the onward development of the Patient Safety Bill, the regulation of children's residential centres and homecare services as well as the inspection of direct provision centres.

Finally, I would also like to thank the members of the HIQA Board for the advice and direction that they provided throughout a very busy year, and our colleagues in the Department of Health. I look forward to continuing to deliver the objectives set out in our Corporate Plan in 2021, which will ensure that HIQA continues to make a positive and constructive contribution to the quality and safety of Ireland's health and social care services.



**Prof Pat O'Mahony**  
Chairperson

# Foreword from the CEO



**Phelim Quinn,**  
CEO

**This annual report provides an overview of our work in 2020 to fulfil our remit, while also working to meet the demands of the COVID-19 pandemic.**

As Chief Executive, I am proud that HIQA has played an active and meaningful role in the national effort to combat COVID-19.

I wish to acknowledge the flexibility and responsiveness of HIQA's staff in delivering not only its planned programme of work, but working to meet a range of additional objectives in very challenging circumstances. On an ongoing basis over the past year, our staff have worked long hours, weekends and bank holidays in the national interest. In doing so, HIQA maintained focus on our core objectives of working to make services safer, continuing to focus on the quality of care being provided, providing advice and evidence to inform local and national decisions about services and policy, and continuing to provide a reliable source of information to the public and our stakeholders.

As is reported by the Chief Inspector of Social Services, one of the greatest impacts on our organisation and our staff has been the effect of the pandemic on some of our most vulnerable citizens and their families. I wish to extend my heartfelt sympathies to the families and loved ones of those who have died as a result of COVID-19. The toll that the pandemic has taken on families and loved ones is clearly evidenced in the significant numbers of people who contacted our support lines seeking advice, guidance and information about the impact of the pandemic on their relatives.

I am proud of the way in which our staff were able to safely maintain our programmes of regulation, as well as working to support planners, policy-makers and service providers to continue to deliver health and social care services in the most challenging of circumstances. Our experience of regulating during the pandemic has without doubt highlighted the need for reform in the way in which services are delivered to our older citizens in particular, but also to better safeguard those who live in unregulated services.

Regulatory reform will be a key focus for HIQA over the coming years, as health and social care services work to meet the long-term consequences of the pandemic.



Furthermore, we adapted to the changing demands and needs of the national public health response to the pandemic. This was particularly evident in the responsive work of our Evidence Synthesis Team in providing international evidence reviews and advice to NPHET, the Department of Health and the HSE on a weekly basis, but also in how we redeployed staff both internally and externally to assist with national efforts.

We also endeavoured to keep the public informed about our work, ensuring transparency and accountability in how health decisions are made, what we found on inspections, and where there was a need for improvement in quality or health information. We continued to develop new standards for services to improve care and support, and make recommendations to improve health information in Ireland.

Throughout the year, we published our advice to NPHET and over 1,100 inspection reports in a timely manner to provide assurances to the public. We also hosted a number of webinars with stakeholders, and developed elearning tools to promote quality improvement in services.

Adapting to remote working brought technological challenges which we quickly adjusted to, ensuring our staff had the equipment and technology to work from home. Staff safety and wellbeing is a continued focus for HIQA. During the year, we adapted how we communicate with, engage and support our staff virtually through a number of initiatives, such as our Wellbeing Programme.

On behalf of the Executive Management Team, I would also like to extend my thanks to the Board for its support and advice throughout the year.

I assure you that HIQA remains committed to working to improve health and social care services for people in Ireland, and will continue to progress this in 2021 and beyond.



**Phelim Quinn**  
CEO

# Message from the Chief Inspector of Social Services<sup>1</sup>



**Mary Dunnion,**  
Chief Inspector of Social  
Services and Director of  
Regulation

**In our previous annual reports, I have described the broad trends in health and social care services from the perspective of the regulator. We generally encounter services that are providing good quality care where residents feel safe and are well looked after. There are always some services that require improvement and I can typically outline what we have done to hold registered providers to account. However, 2020 was not a normal year. The COVID-19 pandemic that swept the country completely overshadowed all other aspects of life. The fear and anxiety brought on by the virus developed into concern for loved ones and uncertainty over what lay ahead.**

This is particularly true for people living in residential care facilities – our elderly in nursing homes and at-risk children and people with disabilities. Their daily lives were changed beyond recognition. Staff wore personal protective equipment, visitors were restricted and there were no more social gatherings, limiting social activities for many. This was deeply traumatic, particularly for those with dementia or who lacked capacity to understand what was happening. Unfortunately, many residents and staff in these services came into contact with the virus.

From the beginning of the pandemic, we were contacted by concerned members of the public. These included bereaved, concerned and sometimes frightened relatives of residents and patients who were unable to visit or speak with their family member and were unclear about what was happening for them. A number of these relatives would previously have visited their loved one daily prior to COVID-19 and actively participated in their care. Some family members told us how they had missed out on spending time with their relatives at the end of their life.

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<sup>1</sup> This annual report constitutes the report of the Chief Inspector of Social Services, as outlined in the Health Act 2007.


During the early stages of the pandemic, we took the decision to temporarily suspend on-site monitoring inspections pending greater public health clarity in regard to the nature and spread of the virus. During this time, we kept in contact with all designated centres, providing advice and support as necessary. This included signposting them to additional support services, such as our Infection Prevention and Control Hub, or escalating any issues to the relevant authorities, for example, access to personal protective equipment, testing or staff shortages.

On-site inspections recommenced in April and we focused our efforts on two key areas: risk inspections and contingency planning assessments. Risk inspections focused on the services with active outbreaks of COVID-19 infection. Our inspectors received full training in the most up-to-date guidance on managing an outbreak in a residential care facility and were also provided with the necessary equipment to ensure their own safety and the safety of the people who they came in contact with. Contingency planning assessments aimed to ensure services that had yet to experience an outbreak were equipped to identify and manage any cases should they arise. The dedication and commitment of our regulatory staff is to be commended and their work contributed to the national effort of all front-line healthcare workers to protect our most vulnerable.

When visiting and inspecting centres, we met and spoke with many residents and staff working in social care services. While residents expressed their sense of fear and isolation, they also praised staff and management who had gone to great lengths to keep them safe. Staff working in centres told our inspectors of the toll wrought by the pandemic: the exhausting extra shifts, losing staff to illness or self-isolation, comforting residents and fielding anxious phone calls from their relatives and friends. The diligence of staff and management in meeting the needs of residents reminds us that working in health and social care is a vocation as much as it is a profession.

As the year progressed, we established a clearer picture of what services were coping well and where additional improvement and support was required. Many nursing homes managed to keep the virus entirely at bay or prevent outbreaks from spreading. Others needed substantial levels of support and, in some cases, intervention by crisis management teams from the HSE.

Similarly, gaps and shortcomings in our regulatory framework were further exposed by COVID-19. HIQA has repeatedly called for a review process to make the current regulations fit for purpose and in line with the changing models of care we see across the country. In particular, clinical governance, staffing levels, as well as effective governance and management, require improvement.



We have also consistently drawn attention to the issue of outdated premises, many of which have multi-occupancy rooms and shared facilities that are not appropriate to provide the quality of care our citizens should be able to enjoy. In their current format, the regulations do not permit me, as the Chief Inspector, to take proportionate action where the safety and privacy of residents is compromised.

We believe that the framework for regulating health and social care requires reform. The way care and support is delivered in Ireland is constantly evolving; for example, the Government has outlined its intention to place homecare services on a statutory footing and disability services continue to move away from congregated settings to more individualised and person-centred supports. Other models of care which permit people to remain at home or in their communities for longer are emerging, but remain underdeveloped. We should look to reform our system of regulation to meet these changes. That means allowing providers more flexibility in how they develop and deliver services, and placing the focus on the service itself, rather than the physical building within which care takes place.

It will take some time before the fallout from the 2020 pandemic is fully appreciated. As we move into 2021, we are acutely aware that this public health emergency is far from over. We will continue our work to regulate services. As always, we endeavour to keep residents and the people using services at the centre of what we do. We will continue to engage with all stakeholders and make the case for regulatory reform that will serve the needs of the nation into the 21st Century.



**Mary Dunnion**

Chief Inspector of Social Services and Director of Regulation

# 1

# About HIQA

## 1.1 Introduction


The Health Information and Quality Authority (HIQA) is the independent authority established in 2007 to drive high-quality and safe care for people using health and social care services in Ireland. HIQA's role is to develop standards, inspect and review health and social care services and support informed decisions on how services are delivered.

This Annual Report outlines the work of HIQA from 1 January to 31 December 2020, in keeping with the statutory requirements of the Health Act 2007, and includes HIQA's arrangements for implementing and maintaining adherence to the Code of Governance for public bodies. It also includes the Report of the Chief Inspector of Social Services and the Annual Governance and Compliance Report, as required by the Health Act 2007, and our annual financial statements.

## 1.2 Our mandate and activities

Our mandate extends across a specified range of public, private and voluntary sector services. Reporting to the Minister for Health and engaging with the Minister for Children, Equality, Disability, Integration and Youth, HIQA has responsibility for the following:

- **Setting standards for health and social care services** – Developing person-centred standards and guidance, based on evidence and international best practice, for health and social care services in Ireland.
- **Regulating social care services** – The Chief Inspector within HIQA is responsible for registering and inspecting residential services for older people and people with a disability, and children's special care units.
- **Regulating health services** – Regulating medical exposure to ionising radiation.
- **Monitoring services** – Monitoring the safety and quality of health services and children's social services, and investigating as necessary serious concerns about the health and welfare of people who use these services.

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- **Health technology assessment** – Evaluating the clinical and cost-effectiveness of health programmes, policies, medicines, medical equipment, diagnostic and surgical techniques, health promotion and protection activities, and providing advice to enable the best use of resources and the best outcomes for people who use our health service.
  - **Health information** – Advising on the efficient and secure collection and sharing of health information, setting standards, evaluating information resources and publishing information on the delivery and performance of Ireland’s health and social care services.
  - **National Care Experience Programme** – Carrying out national service-user experience surveys across a range of health services, in conjunction with the Department of Health and the HSE.

The statutory functions that provide the basis for HIQA’s work are outlined in the Health Act 2007, the Child Care Acts 1991 and 2001 (as amended), the Children Act 2001, the Education for Persons with Special Educational Needs Act 2004, and the Disability Act 2005.

# 2

## Governance and management

### 2.1 Our Board

The Board is the governing body of HIQA and was first established on 15 May 2007. The Board is responsible for the appropriate governance of HIQA, ensuring effective systems of internal control, statutory and operational compliance and risk management. These provide the essential elements of effective corporate governance and compliance.

Membership of the Board is made up of a Chairperson and 11 non-executive directors who have been appointed by the Minister for Health. The Board members have specific experience and expertise in matters connected with HIQA's functions, and come from a range of health and social care professions and industries.

The members of the Board during 2020 included:



**Prof Pat O'Mahony** (Chairperson)

Chief Executive of Clinical Research Development Ireland. Former Chairman of the Management Board of the European Medicines Agency. Former Deputy Secretary General and Head of Governance and Performance at the Department of Health. Former Chief Executive of the Health Products Regulatory Authority.



**Bernadette Costello**

Chartered Director and Chartered Accountant. Former Director of Internal Audit & Risk Management, National University of Ireland, Galway. Currently member of Board and Chair of the Audit and Risk Committee of Oberstown Children Detention Campus; Board and Finance Committee of Galway and Roscommon Education and Training; and Galway Harbour Audit & Risk Committee.



### **Dr Jim Kiely**

Vice Chair of the Board of Tallaght University Hospital and a member of the Commencement, Transition and Integration Committee for the National Children's Hospital. Former Chief Medical Officer in the Department of Health.



### **Dr Paula Kilbane**

Formerly CEO of Eastern Health and Social Services Board in Northern Ireland and Director of Public Health of the Southern Health Board Northern Ireland. Currently a director of a number of boards in the private, public and charitable sectors.



### **Tony McNamara**

Insight Management Consultancy. Former CEO of Cork University Hospital. Served on various national advisory and consultancy bodies for the Department of Health. Former board member of Irish Blood Transfusion Board, Road Safety Authority and Health Insurance Authority.



### **Lynsey Perdisatt**

Senior HR professional having worked in both the private and public sector, with significant experience in employee relations, industrial relations and change management.



### **Prof Michael Rigby**

Extensive experience in health service development and delivery, and in research into health policy and management in UK and Ireland. Member of the Roster of Experts appointed to support WHO Digital Health Technical Advisory Group.



### **Caroline Spillane**

Director General of Engineers Ireland. Former CEO of the Medical Council of Ireland. Former Assistant National Director with the HSE and CEO of the Crisis Pregnancy Agency.



The following members stood down from the Board in 2020:



**Enda Connolly**

Chairman (Designate) of Beaumont Hospital. Former Chief Executive of the Health Research Board and former Executive Management Team member of IDA Ireland.



**Molly Buckley**

Public health nurse. Vice Chairperson of the Irish Council for Social Housing and a director and chairperson of a number of national and international social inclusion organisations and projects.



**Martin Sisk**

Solicitor. Independent Non-Executive Director of the Interim Board of the Office of Government Procurement. Director of the Irish League of Credit Unions. Chairman of the Irish Auditing and Accounting Supervisory Authority. Commissioner on the State Examinations Commission.



**Stephen O'Flaherty**

Qualified accountant with the Association of Chartered Certified Accountants who worked with AIB Business Banking and is now a director with BDO.



## 2.2 Board meetings

Under the Health Act 2007 the Board is required to meet six times annually. In total, HIQA's Board met 11 times during 2020 to progress various significant matters (see Chapter 5 for more detail on our Board's activities in 2020).

## 2.3 Board committees

Four Board committees support the activities of the Board in governing HIQA:

- Regulation Committee oversees the effectiveness, governance, compliance and controls around the delivery of HIQA's regulatory functions.
- Audit, Risk and Governance Committee supports the Board in relation to its responsibilities for issues of risk, control and governance and associated assurance. The Audit, Risk and Governance Committee is independent from the financial management of the organisation. In particular, the committee ensures that the internal control systems, including audit activities, are monitored actively and independently. The committee reports to the Board after each meeting, and formally in writing annually.
- Standards, Information, Research and Technology Committee oversees the governance arrangements, including compliance and controls, for the functions of standards development, health information and health technology assessment functions.
- Resources Oversight Committee monitors the resource requirements of HIQA to ensure that they are aligned with HIQA's corporate strategy, including oversight of resource related risks. In addition, it oversees organisational needs and managerial performance.

## 2.4 Executive Management Team

HIQA's organisational structure reflects the core functions and activities of Regulation, Health Technology Assessment and Health Information and Standards, together with the support services that enable us to achieve our corporate objectives: the Chief Executive's Office, Operations, Information Division and Communications and Stakeholder Engagement. The organisation is led by the Executive Management Team which is supported by other senior managers who are responsible for our business functions.

The membership of HIQA's Executive Management Team during 2020 included:



**Phelim Quinn**

Chief Executive



**Dr Máirín Ryan**

Director of Health Technology Assessment and Deputy Chief Executive



**Mary Dunnion**

Director of Regulation and Chief Inspector of Social Services



**Rachel Flynn**

Director of Health Information and Standards



**Sean Angland**

Acting Chief Operations Officer

## 2.5 Corporate governance

HIQA's Board is responsible for our system of internal controls and for annually reviewing the effectiveness of these controls, including financial, operational and compliance controls, and risk management.

To deliver on this responsibility, the Audit, Risk and Governance Committee takes an active role in coordinating the assurances derived from various sources, such as:

- internal audit work
- audit by Comptroller and Auditor General
- risk management
- review of financial controls
- review of financial statements.

In addition:

- The Executive Management Team provides an annual assurance statement to the Board, which sets out the controls covering the totality of HIQA's functions.
- Regular corporate performance reports are provided to the Board, including corporate risks.
- The Chief Executive provides a report at each meeting of the Board.
- The four Board committees report to the Board.

### **Compliance with the Code of Practice for the Governance of State Bodies**

HIQA has a Code of Governance, Code of Business Conduct and related governance policies and procedures to ensure its compliance with the revised Code of Practice for the Governance of State Bodies.

HIQA was recertified for the SWiFT 3000 Governance Standard from the National Standards Authority of Ireland. A detailed Annual Governance and Compliance report is included with the annual financial statements for 2020.

# 3

## Strategic objectives

### Mission statement

Working to improve health and social care services for people in Ireland.



### Our vision

#### **Safer Services**

We work to protect and safeguard service users

#### **Better Care**

We work to improve the quality of health and social care services

#### **Better Decisions**

We work advice, evidence and information to inform local and national decisions about services

#### **Independent Assessment**

We provide a reliable source of information for the public and our stakeholders

## Our values

HIQA is driven by its values, which reflect the essence of the legislation that defines our remit.

### HIQA values

### In practice, this means we will:



**Putting people first**

Put the needs, voices, rights and protection of people who use health and social care services at the centre of our work.



**Being fair and objective**

Be fair and objective in our dealings with people and organisations.



**Being open and accountable**

Communicate the nature and outcomes of our work and accept full responsibility for our actions.



**Striving for excellence**

Continually improve the quality of our work and use the best available evidence.



**Working together**

Listen to and work with those funding, planning, providing and using health and social care services.

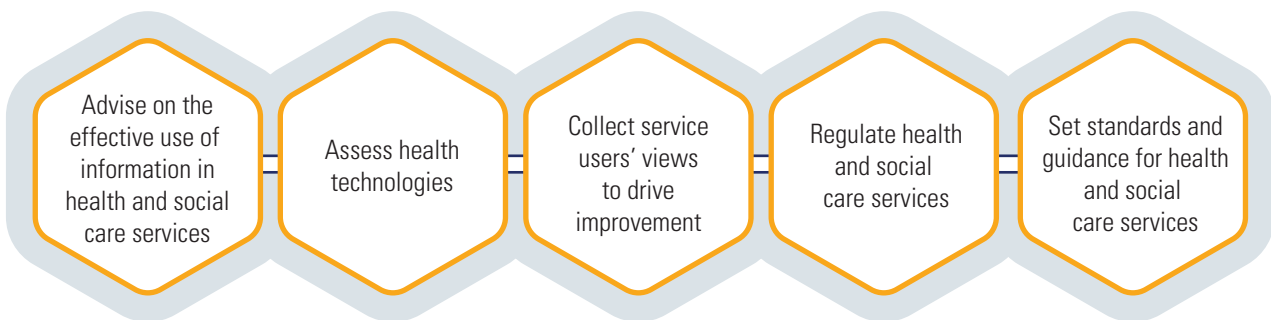
## 3.2 Strategic objectives

HIQA's Corporate Plan 2019–2021 sets out the framework and strategic objectives that enable us to meet existing and new obligations. This plan outlines the direction and focus of the organisation for the period, and sets out our strategic objectives, as follows:

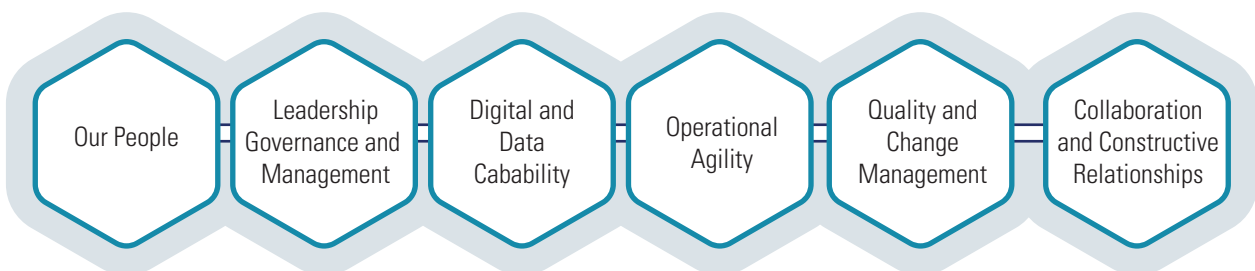
### Our Vision



### Our Strategic Objectives



### What we need to be successful



These objectives, priorities and commitments, articulated within the Corporate Plan, are met through objectives set out in our annual business plan. Due to the global coronavirus pandemic, our business plan was substantially revised after the first quarter of 2020 to meet the challenges presented by COVID-19 in Ireland. Read our 2020 business plan on [www.hiqa.ie](http://www.hiqa.ie). Progress in achieving these objectives is summarised in the next chapter.

# 2020 in numbers

**1,242**

inspections of health and social care services



**49**

evidence synthesis reports developed on COVID-19



**16,362**

people took our elearning module on infection prevention and control



**1,450**

attended our webinars on COVID-19 preparedness in designated centres



**1,838**

concerns received about health and social care services



**4,842**

people took our elearning module on adult safeguarding



**3,204**

women took part in first National Maternity Experience Survey



**1,200**

participants in National Public Engagement Survey on Health Information



**588**

dental providers attended webinars on rollout of inspections of dental X-ray services



# 4

## Key activities

**Our Business Plan 2020 set out an ambitious agenda to fulfil the strategic objectives in our Corporate Plan 2019–2021. This chapter sets out how HIQA has met these objectives, while also fulfilling our vision.**

### 4.1 Report of the Chief Inspector and Regulation Directorate

HIQA was established to drive high-quality and safe care for people using Ireland's health and social care services. We do this through regulating social services and inspecting and monitoring public health services and children's social services.


The Chief Inspector of Social Services and HIQA's Regulation Directorate carry out inspection and monitoring activities to assess the standard and quality of health and social care services and make recommendations for improvement, where required.

The Chief Inspector oversees the registration and regulation of designated centres for adults and children, while the Director of Regulation is responsible for monitoring the quality and safety of health and unregistered social services.

Regulation and monitoring of services is divided into four specialty pillars:

- designated centres for older people
- designated centres for people with disabilities
- healthcare
- children's services.

In addition, we also receive, analyse and risk-assess information from a range of sources. This includes notifications from providers relating to specific events, as set out in the regulations, as well as residents, people who use services, relatives, staff, advocates or third parties submitting information. All this information is used to inform our assessment of compliance and risk within services, and further inform our monitoring and inspection programme.



All our regulatory judgments are published, thereby ensuring transparency and that service users, their relatives, public representatives, services providers and the relevant government departments are aware of the levels of compliance with mandated regulations and standards, areas of good practice and the level of risk across services.

In addition, HIQA may undertake an investigation as to the safety, quality and standards of the services described in section 8(1) (b) of the Health Act if HIQA believes, on reasonable grounds, that there is a serious risk to the health or welfare of persons using those services. The Minister may also require HIQA to undertake an investigation in accordance with Section 9 of the Act.

#### **4.1.1 Regulation of nursing homes**

2020 has been a year of unprecedented challenge for the nursing home sector. COVID-19 has had a profound effect on the lives of older people residing in nursing homes and their relatives, the providers of services, staff and the wider communities within which nursing homes are located.

The impact of COVID-19 on nursing homes has been pervasive with many older people living in nursing homes sadly dying as a result of COVID-19. Their loss has been deeply felt by the companions they had shared their home with, their families, staff members and the wider communities. Others who continue to live in nursing homes have seen the quality of their daily lives impacted by the restrictions deemed necessary to protect them, such as physical distancing, the use of personal protective equipment (PPE), intermittent requirements to isolate within their home, and severely limited visits from family and friends.

As detailed in this report, 82% of nursing homes reported at least one confirmed COVID-19 case among staff or residents in 2020. However, this percentage does not convey the constant anxiety experienced by providers and their staff as they moved from an initial focus on prevention and then, if necessary, escalating to the recognition, management and containment of an outbreak. Over the past year, nursing home providers and staff have had to assimilate to and process frequently-changing national guidance on the management of COVID-19. In addition, providers have faced additional challenges when contingency plans did not meet the challenge of an outbreak, and their baseline staffing models prevented the creation of 'pods' which might have reduced the impact of an outbreak.

Providers and staff have been supported in their fight against COVID-19 by the collective efforts of the wider healthcare community, including the Department of Health, local public health officials, and gerontology and medical teams who reached out from the acute services. Undoubtedly, the crisis management teams, organised in each HSE community health organisation, have been crucial in supporting many centres in crisis.

From the onset of this pandemic, HIQA has maintained regular contact with nursing home providers monitoring and supporting their ability to manage an outbreak. We have shared learning from one nursing home to another, directed providers to additional supports and, where necessary, escalated issues that providers and managers reported to us to the HSE, such as the need for access to PPE, serial testing and centre-specific infection prevention and control or public health advice; access to funding; and, in some cases, requests for replacement staff on an interim basis.

Notwithstanding the hope that is associated with vaccination, COVID-19 continues to present a real and present danger to all who live and work in nursing homes. In the interim of overcoming this disease, we must remain vigilant and do everything we can to shield the most vulnerable from this virus. We will continue to work with all nursing home providers to ensure that people are kept safe, while also receiving a good quality of life.

**Registration**

As of 31 December 2020, there were 573 registered designated centres for older people (nursing homes) in Ireland, with 32,091 registered beds.

These figures represent a reduction of 12 in the total number of nursing homes since the end of the previous year, but a small increase (+122) in the number of registered beds. During the year, in response to the COVID-19 pandemic, the HSE repurposed a number of nursing homes to function as step down units, COVID-19 response units or other short-term care facilities. As a result, there are now 113 State-provided nursing homes compared to 122 at the end of 2019.

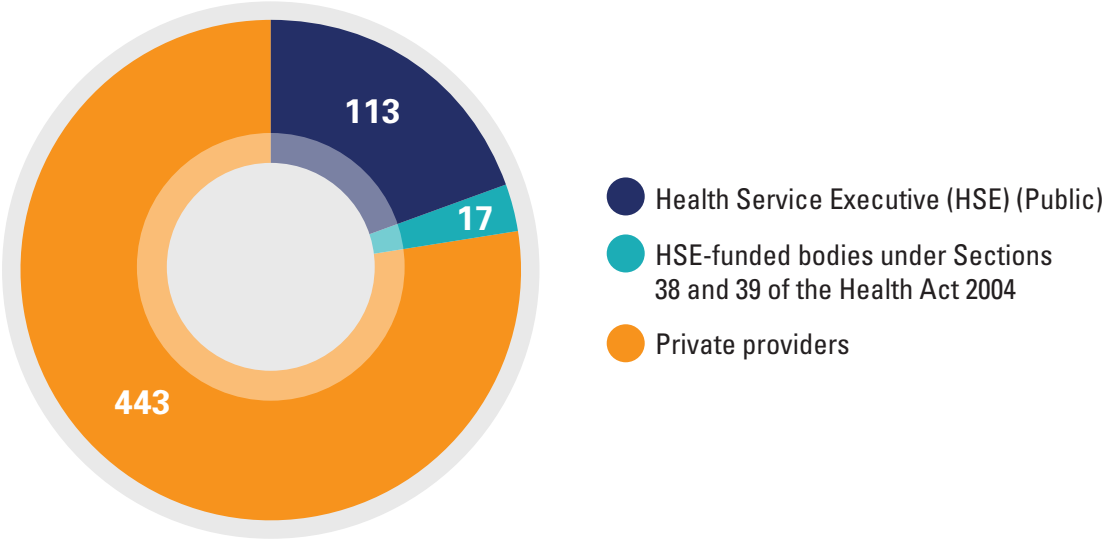
Nursing homes may be owned and operated by a number of legal entities, including:

- the HSE
- HSE-funded bodies under sections 38 and 39 of the Health Act 2004
- private providers

The vast majority (80%) of nursing homes are owned and operated by private providers.

Figure 1 sets out the profile of ownership of nursing homes at the end of 2020.

Figure 1 - Nursing homes classified by ownership<sup>2</sup>



**Bed capacity**

In 2020, new nursing home beds became available through the registration of 11 new nursing homes and extensions in 28 existing nursing homes. New nursing homes provided 668 new beds, while extensions to existing nursing homes accounted for a further 462 beds.

Private providers own and operate 79% of the new beds registered in 2020, with the remainder owned and or operated as statutory centres.<sup>3</sup> However, four<sup>4</sup> of the new statutory nursing homes registered in 2020 were built to replace existing outdated facilities and, as such, can be considered replacement beds rather than new beds.

2 Section 38 of the Health Act 2004 states that the HSE can have an arrangement with a person to provide a health or personal social service on behalf of the HSE. Section 39 of the Health Act 2004 states that the HSE can provide assistance to any person or body providing a similar service to the HSE.  
3 Statutory centres include centres owned and operated by the HSE, in addition to centres receiving funding under sections 38 and 39 of the Health Act 2004.  
4 Waterford Residential Care Centre replaced St Patrick’s Hospital in Waterford. Cashel Residential Older Persons Services replaced St. Patrick’s Hospital in Tipperary, Tymon North Community Nursing Unit replaced St Brigid’s Home in Dublin and Peamount Healthcare was replaced by Peamount Healthcare Older Persons Service in Dublin.

**Table 1 - Details geographical location of new beds registered in 2020**

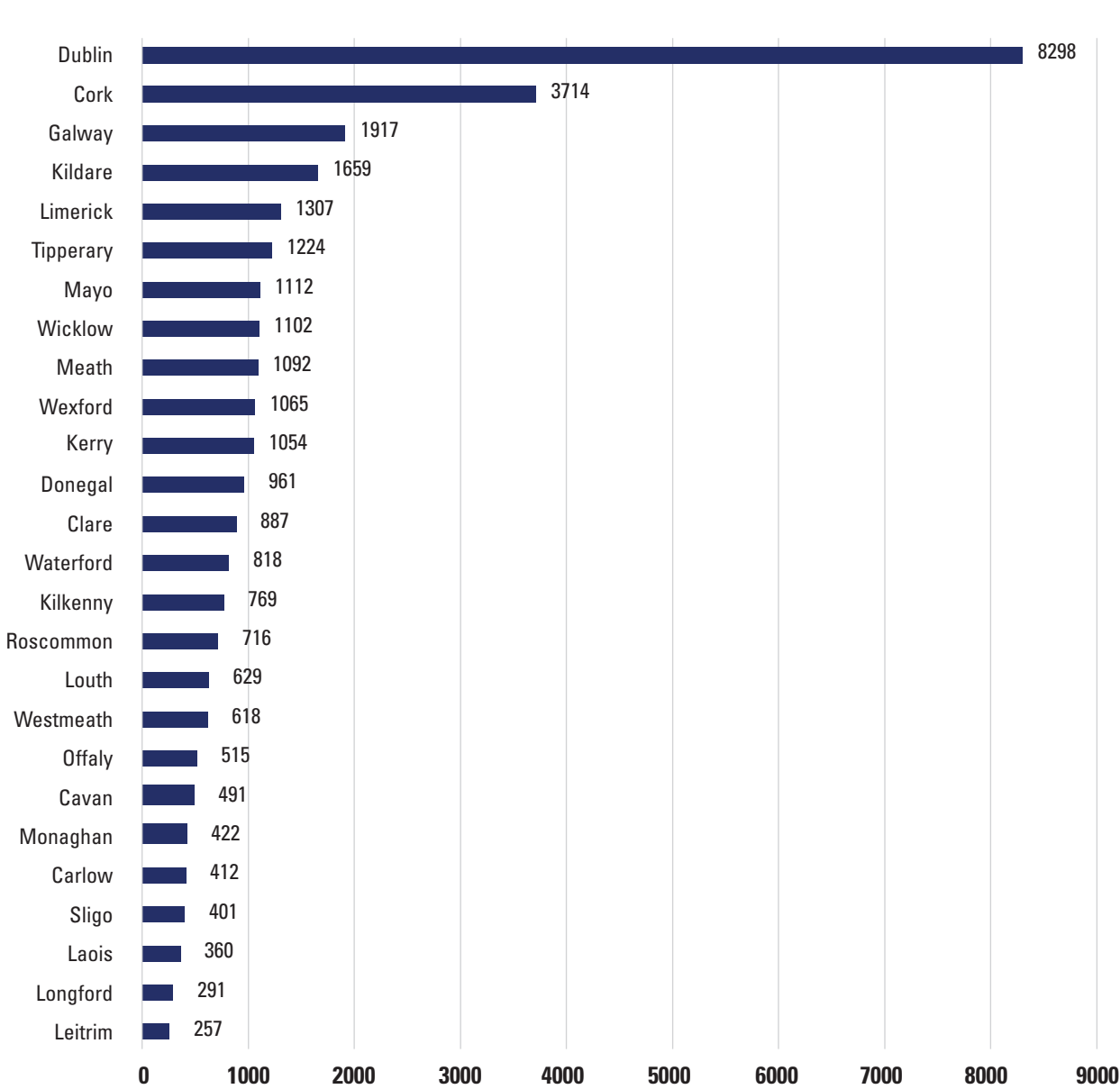
Location of new beds	Number of new beds
Dublin	501
Waterford	169
Tipperary	132
Kerry	81
Cork	44
Kildare	40
Galway	33
Kilkenny	33
Limerick	26
Meath	26
Donegal	21
Wexford	18
Monaghan	4
Louth	2

The number of registered beds also changed due to the closure of nursing homes or by a reduction in the number of beds in an existing nursing home. In 2020:

- 33 centres reduced capacity resulting in a decrease of 171 beds
- 23 centres closed which resulted in a decrease of 837 beds
  - 21 centres closed voluntarily
  - two centres were closed under Section 59 of the Health Act 2007.

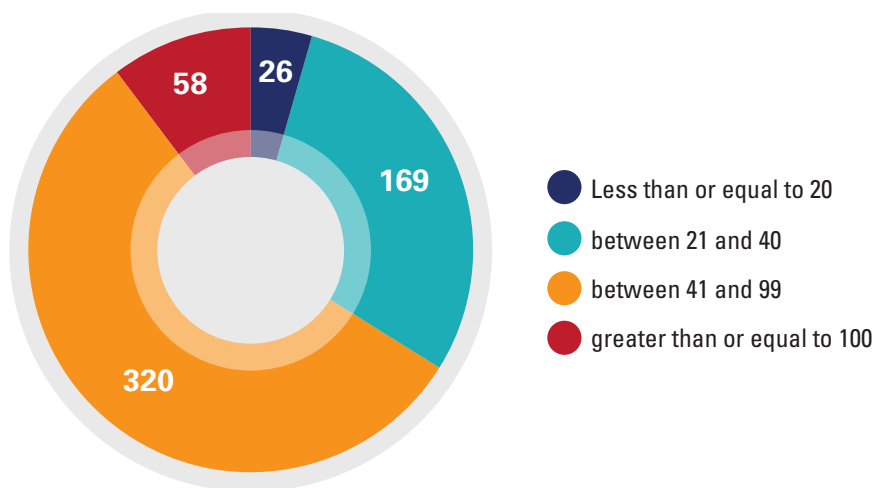
Table 2 details the current geographical distribution of nursing homes and the number of beds registered by the Chief Inspector at 31 December 2020.

**Table 2 - Number of registered beds per county 2020**



The percentage of nursing homes with 100 or more beds was 7% in 2020; a modest increase of four homes from 2019.

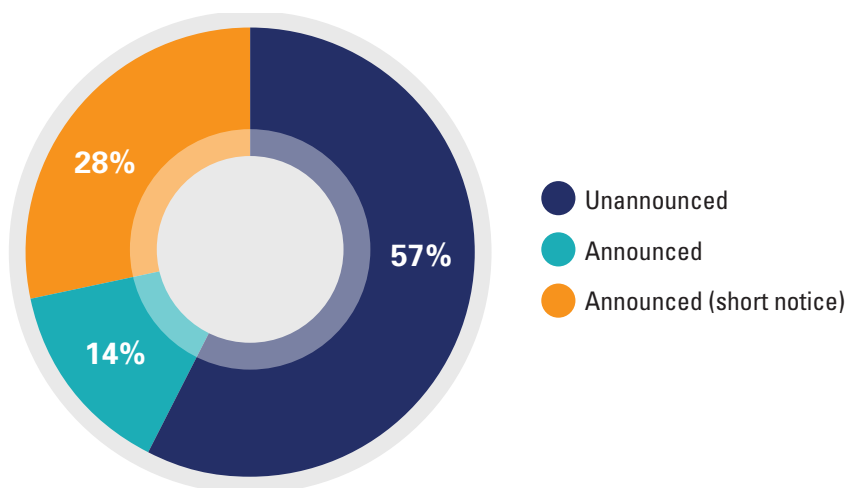
**Figure 2 - Bed numbers in registered designated centres for older people, as of 31 December 2020**



### Inspections

In 2020, we carried out 392 inspections of 323 nursing homes. An inspection of a nursing home may be announced, short notice announced<sup>5</sup> or unannounced. The majority of inspections (57%) were unannounced, 14% of inspections carried out in 2020 were announced, while 28% of inspections were short notice announced.

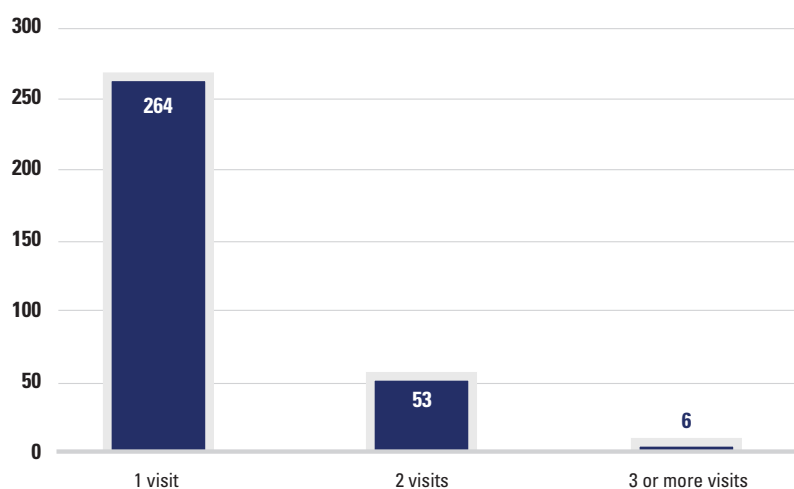
**Figure 3 - Percentage of announced, short notice announced and unannounced inspections of nursing homes carried out in 2020**



The vast majority of nursing homes inspected in 2020 received one inspection during the course of the year. However, reported regulatory non-compliance and associated concerns about the care and welfare of residents in a small number of centres generated more than two inspections. Six nursing homes required three or more inspections during 2020. This represented 2% of all nursing homes inspected over the year.

<sup>5</sup> Short notice announced inspections give the provider a maximum of 48-hours notice prior to inspection.

**Figure 4 - Number of inspection visits per centre inspected in 2020**



### **National Public Health Emergency – COVID-19**

On 12 March 2020, in response to the onset of the COVID-19 pandemic, the Chief Inspector temporarily suspended all routine regulatory and monitoring inspections. This decision was necessary pending greater public health clarity in regard to the nature and spread of the virus.

During this time, a quality assurance process was set up, to ensure an inspector had contact with a nursing home, at a minimum, on a fortnightly basis. These calls with the person in charge and or provider provided important assurance regarding the welfare of the residents, how nursing homes were coping, any concerns they had and any deficiencies identified in their ability to sustain a safe, high-quality service. Between 13 March and 27 June 2020, 2,851 such phone calls were made.

In addition, between 29 April and 26 May 2020, inspectors completed a total of 189<sup>6</sup> compliance assessments across 189 centres that were free from COVID-19 to ensure they had contingency measures in place for a COVID-19 outbreak. These assessments were based on the regulatory assessment framework for the preparedness of designated centres for older people for a COVID-19 outbreak.

The assessment programme concluded on 26 May 2020 when risk inspections of nursing homes recommenced. These inspections primarily focused on nursing homes that had reported an outbreak of COVID-19. The findings from these assessments in nursing homes is set out in a report published in July 2020 entitled *The impact of COVID-19 on nursing homes in Ireland*. The report sets out an overview of inspection findings, and also describes the experience of residents and staff as recounted to inspectors. Residents expressed a great deal of fear and anxiety and found the isolation of visiting restrictions difficult to cope with. Staff and management told inspectors about the pressure on them to protect residents and the additional strain caused by staff shortages.

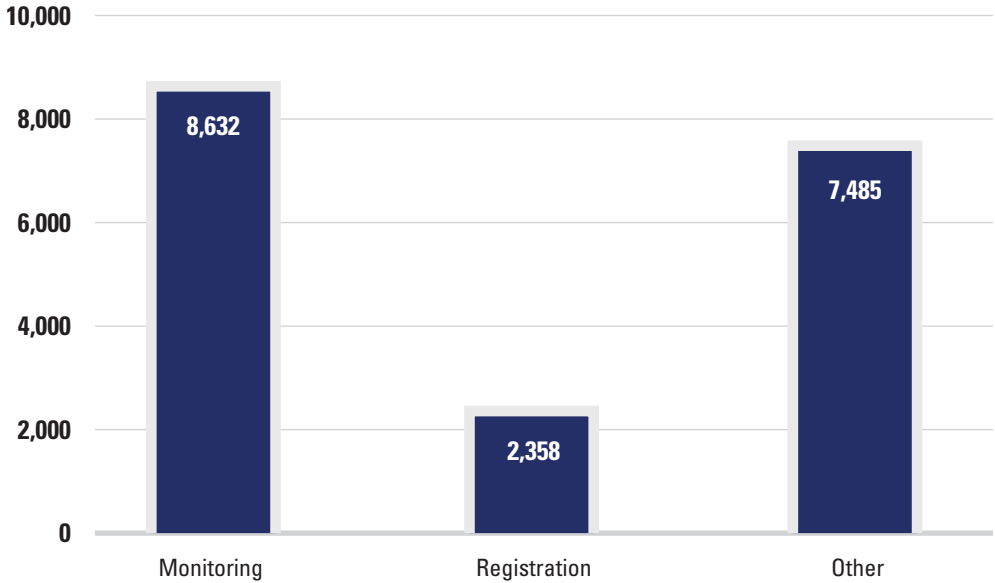
<sup>6</sup> One of the 189 contingency assessments became a risk inspection when inspectors arrived at the centre.



### Receipt of information

Providers or persons in charge are required to submit notifications of significant events that occur in a centre within three days, and to notify the Chief Inspector of other specific matters in the centre on a quarterly basis. These notifications are risk assessed and inform our regulatory actions. During 2020, we received 18,475 notifications from nursing homes.

**Figure 5 - Regulatory notifications received from nursing homes in 2020**



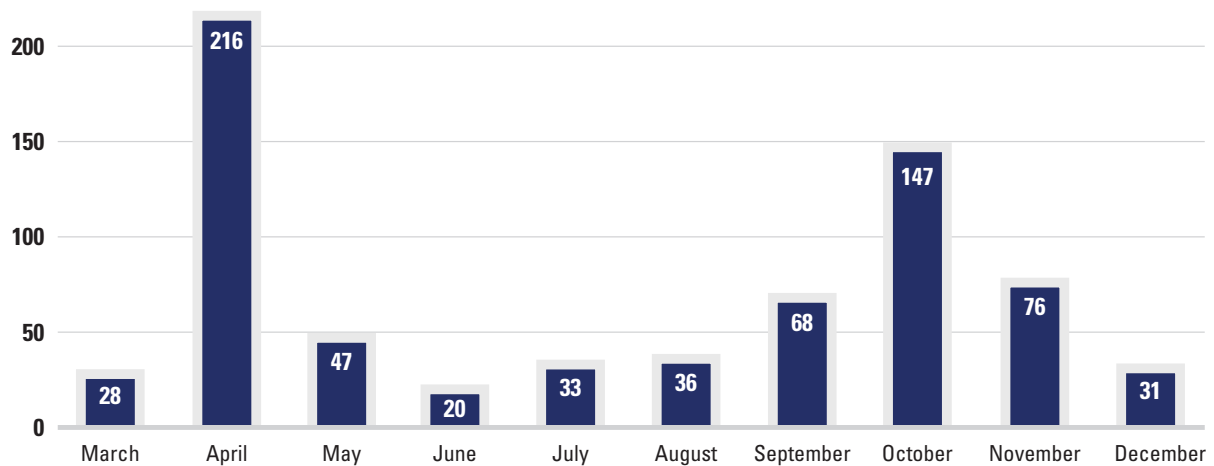
This represents an overall increase of 3,683 notifications since 2019, with the most notable increase seen in monitoring notifications.

We also receive concerns about nursing homes from members of the public who have a concern or an issue with the care provided to residents. During 2020, we received 1,213 pieces of unsolicited information relating to nursing homes, a 71% increase on the number received in 2019. The types of unsolicited information we receive include concerns relating to admissions and contracts, complaints, links with the community, general welfare and development, governance and management, health and safety, risk management, healthcare, medicines management, residents' rights, premises, safeguarding and safety, social care needs and workforce. All items of unsolicited information are risk rated and appropriate action is taken to support our inspection programme.

## Notifications of COVID-19 in nursing homes

Nursing home providers are required to notify the Chief Inspector of any outbreak of infectious disease in a centre. In the context of COVID-19, providers are required to notify the Chief Inspector when one or more residents or staff members is suspected or confirmed to have COVID-19.<sup>7</sup>

**Figure 6 - Number of notifications received from March to December 2020 reporting a resident or staff member with confirmed COVID-19**



The first confirmed case of COVID-19 in a nursing home in Ireland was reported to HIQA on 13 March 2020. By 31 December 2020:

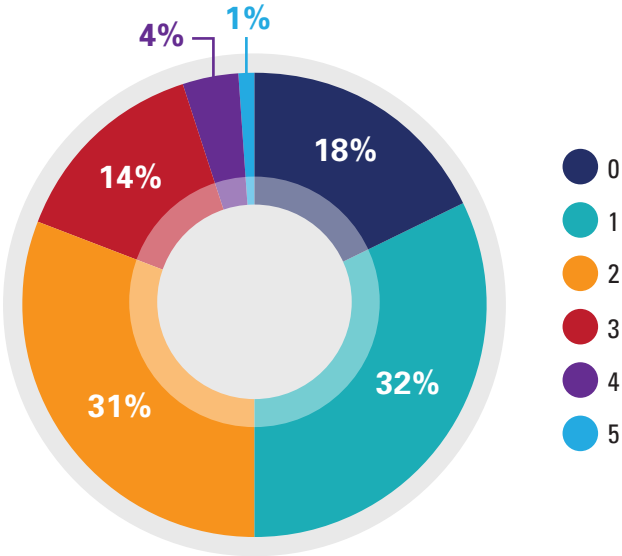
- 82% of nursing homes had reported at least one case of confirmed COVID-19 (residents or staff)
- 18% of nursing homes had not reported a case of suspected COVID-19 (residents or staff). Of these,
  - 13% reported a suspected case, but subsequently advised that it was not actually COVID-19
  - 5% of nursing homes reported no cases of confirmed or suspected COVID-19.

<sup>7</sup> On 20 April 2020, the Chief Inspector issued a regulatory notice regarding an enhanced portal (online) notification form to facilitate the provider's regulatory obligation to notify the Chief Inspector of any outbreak of any notifiable disease and ensure regulatory oversight.

The reporting of COVID-19 in nursing homes reflected the chronological spread of the pandemic in the population as a whole. Review of the notifications show that 81% of privately owned nursing homes and 82% of statutory<sup>8</sup> centres have reported at least one confirmed COVID-19 care in a resident or staff member.

As of 31 December, 702 outbreaks<sup>9</sup> had been reported across registered nursing homes.

**Figure 7 - Percentage of centres that reported more than one COVID-19 outbreak in at their centre in 2020**

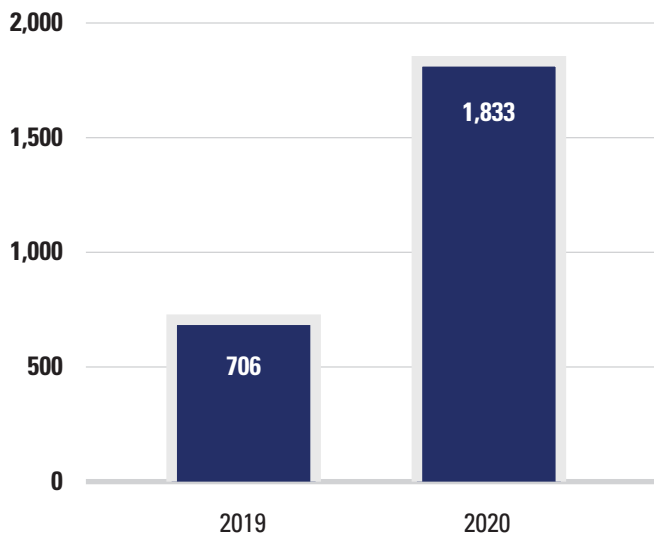


In addition to notifying the Chief Inspector of confirmed or suspected outbreaks of COVID-19, nursing home providers are required to inform the Chief Inspector about unexpected deaths. A review of the number of deaths reported to the Chief Inspector in 2020 compared to 2019 shows a significant increase in the number of unexpected deaths in nursing homes.

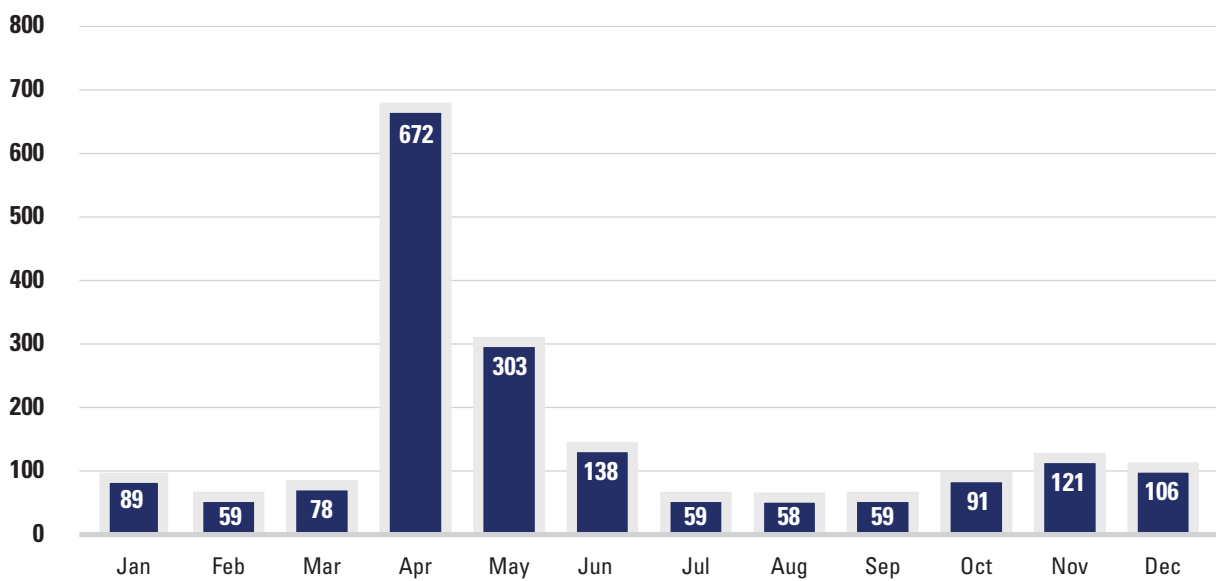
8 This includes HSE-run centres and centres operated under Section 38 and Section 39 of the Health Act 2007.

9 One or more resident or staff member confirmed to have COVID-19.

**Figure 8 - Notifications of an unexpected death in 2020 compared to 2019**



**Figure 9 - Notifications of an unexpected death received between January and December 2020**



## Stakeholder engagement

The impact of COVID-19 on residents of nursing homes and their families saw a significant increase in the number of relatives who contacted us. Some wanted to alert inspectors to issues of concern they had regarding the care of relatives in a nursing home, while others were seeking information in relation to the care of their relative who had sadly passed away. In July 2020, we published a report on the impact of the COVID-19 pandemic on nursing homes in Ireland which described the experiences of residents, their relatives and staff as detailed to us during the first wave of the pandemic.

COVID-19 also impacted some aspects of our engagement with key stakeholders of older people's services. For example, the need to avoid large in-person gatherings resulted in the cancellation of our annual regional forums with providers and residents. Instead, we participated in virtual forums that were focused on sharing information and best practice in relation to keeping residents and staff in nursing homes safe during the national pandemic.

Listening to residents and observing their day-to-day lived experience is a fundamental aspect of all our inspection activity. Notwithstanding the difficulties presented by the use of personal protective equipment (particularly masks), maintaining physical distancing and ensuring conversations do not exceed 15 minutes, we have continued to speak to residents on inspections and listen to their views of the service they received. During the year, we also reviewed how we present residents' feedback in our inspection reports.

## Oireachtas

Our CEO, Phelim Quinn, and Chief Inspector of Social Services, Mary Dunnion, attended Dáil Éireann on 26 May to answer questions on COVID-19 in nursing homes at the Special Committee on Covid-19 Response.

On 10 September 2020, our CEO Phelim Quinn, Chief Inspector of Social Services Mary Dunnion, and Deputy Chief Inspector Susan Cliffe attended the Special Committee on Covid-19 Response to discuss and answer questions on our report on *The impact of COVID-19 in nursing homes*.



### **4.1.2 Regulation of designated centres for people (adults and children) with disabilities**

In March 2020, COVID-19 began to have a significant impact on the lives and experiences of adults and children with disabilities who live in residential accommodation or avail of respite services. For many residents, public health restrictions meant that their community-based day services were closed and they were required to isolate at home. This significantly impacted residents' daily routines, friendships, family contacts and work.

The impact of the public health emergency created a series of significant challenges for providers of disability services to manage the risk of COVID-19 and the impact on staff resources to ensure the continuity of support and care to residents in designated centres. In many centres, residents have underlying health conditions which make them more vulnerable to the risk of infection and makes it all the more imperative that providers have robust COVID-19 management plans.

Supporting providers to respond to COVID-19 and to effectively implement their own COVID-19 risk management plans and prevailing public health advice, was a crucial component of the Chief Inspector's regulatory response to the public health emergency. For example, in March 2020 the Chief Inspector put temporary provisions in place to enable providers to respond quickly to required changes in their centres or to add additional premises to their registered centres to help manage a COVID-19 outbreak, while inspectors continued to ensure that residents were protected by the regulations.

In the majority of centres, we found that providers were working tirelessly to ensure that the quality of life and lived experiences for residents were promoted within the constraints of national restrictions. Throughout the progression of the disease, and through each period of lockdown there was good evidence of provider organisations working together to manage the risk to residents and evidence of effective collaboration between providers, the HSE and public health.

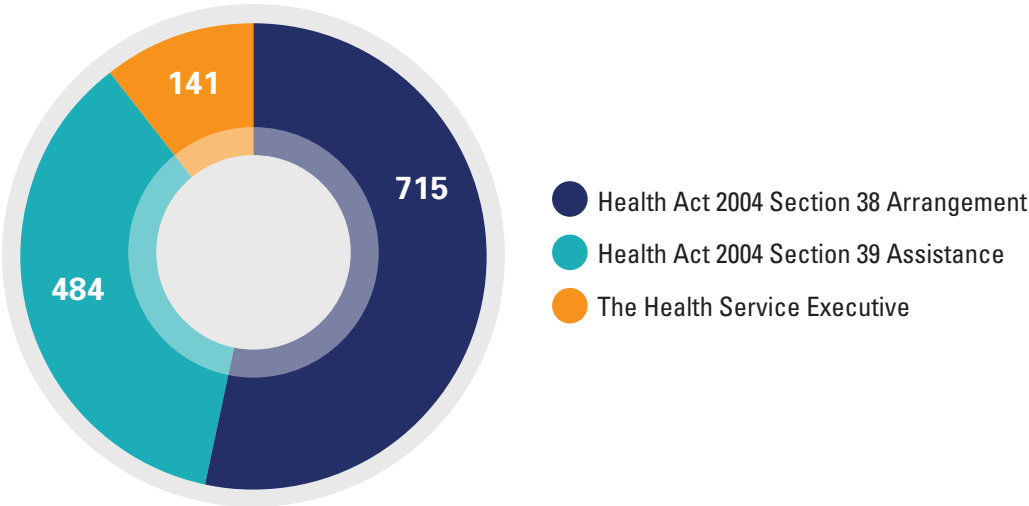
During this period, inspectors also focused on the rights of residents and their experiences in comparison with the overall community. In some instances, inspectors identified where providers had placed excessive restrictions on the rights of residents. For example, when national restrictions had been eased to permit people to meet with physical distancing in public, these arrangements had not been put in place for some residents living in some designated centres. These residents continued to experience a high level of isolation from their community and family. Inspectors brought such restrictions to the attention of the provider and required them to take action to ensure that any restrictions were based on each resident's assessed support needs and in accordance with prevailing public health guidelines.

## Registration

As of 31 December 2020, there were 1,340 registered centres providing residential services to adults and children with disabilities. While the vast majority of these designated centres provide services to adults, 40 of them provide services to a mix of adults and children, the majority of which are respite centres that accommodate children and adults at different times. There are 85 centres specifically for children with a disability.

The 1,340 designated centres for people with disabilities provided 9,166 residential places. These included both long-term and respite placements for 8,558 adults, 257 in centres providing a mix of adult or children’s places, and 351 children’s places.

**Figure 10 - Number of registered designated centres for people with disabilities (by provider type) at 31 December 2020<sup>10</sup>**

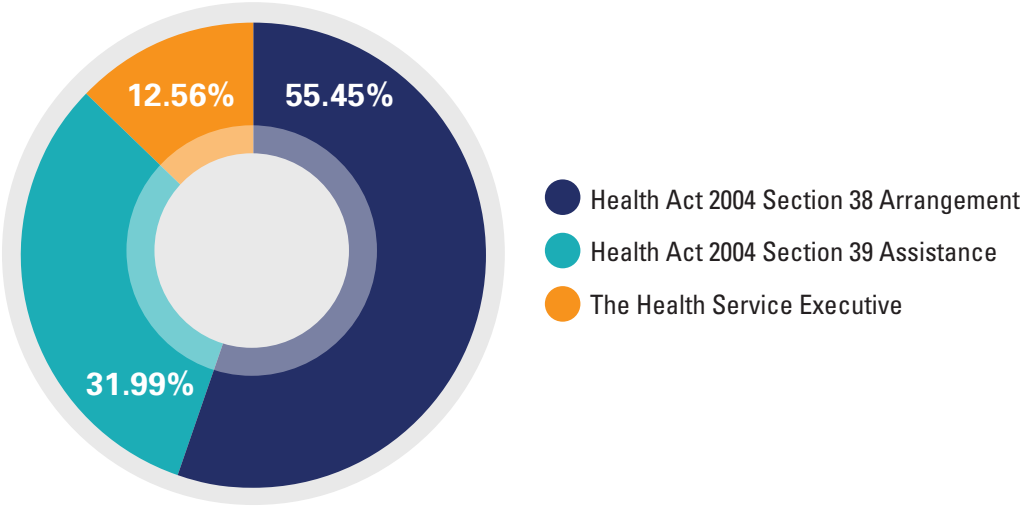


The HSE directly provided 1,151 (12.6%) of these places, with 5,083 places (55.5%) provided through a Section 38 HSE-funding arrangement, and 2,928 places (31.9%) provided through Section 39 assistance by the HSE to providers.

10 Section 38 of the Health Act 2004 states that the HSE can have an arrangement with a person to provide a health or personal social service on behalf of the HSE. Section 39 of the Health Act 2004 states that the HSE can provide assistance to any person or body providing a similar service to the HSE.

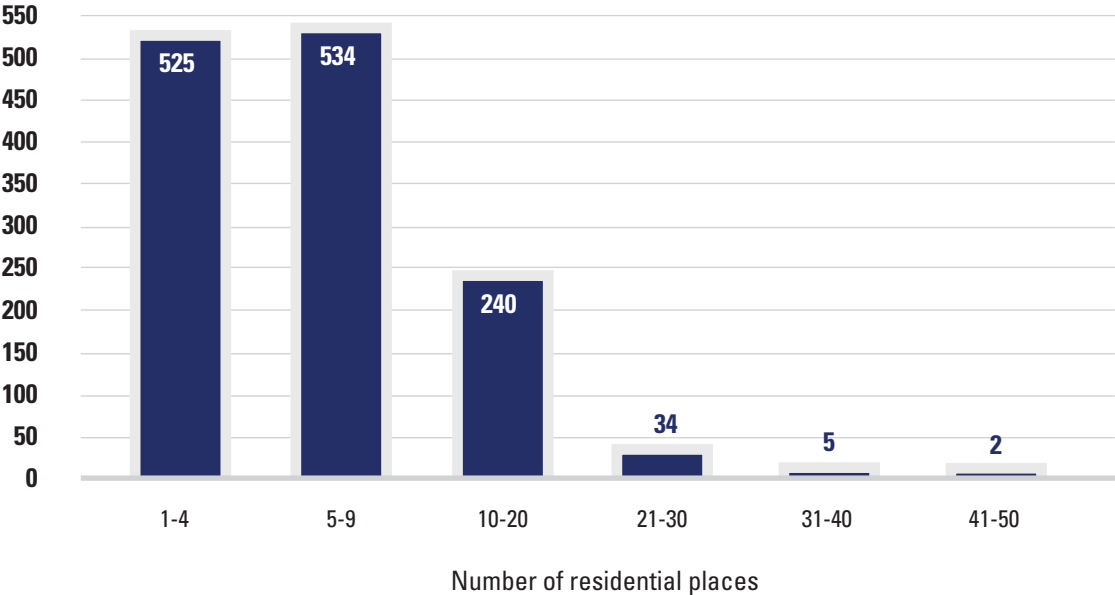



**Figure 11 - Percentage of places provided for people with a disability based on funding arrangement of the designated centre at 31 December 2020**



These centres can comprise of more than one building and each of these buildings may be dispersed within a community setting, co-located in a town or housing estate, a standalone building or a cluster of buildings located together on a campus.

**Figure 12 - Bed numbers in registered designated centres for people with a disability as of 31 December 2020**





While there has been a continued effort within the residential disability sector to reduce and ultimately close all large congregated settings in line with the HSE's national policy,<sup>11</sup> many residents continue to be accommodated in congregated settings. The national policy on congregated settings defines a congregated setting as follows:

*“Congregated settings are where 10 or more people with a disability live together in a single living unit or are placed in accommodation that is campus based. In most cases, people are grouped together and often live isolated lives away from the community, family and friends. Many experience institutional living conditions where they lack basic privacy and dignity.”*

Of the 9,166 residential places registered by the end of 2020, 31% or 2,841 places continued to be located in congregated settings. Of these, 2,196 residential places were within 167 designated centres located on 58 campus-based settings. These campuses may be registered as a single designated centre or may be sub-divided into a number of designated centres. While the number of residents in each centre may vary, all of the buildings which comprise each designated centre are based on the same site.

In addition, 645 residential places were located within 46 designated centres which were registered as standalone congregated settings for 10 or more people.

### **Inspection activity and regulatory response to COVID-19**

During 2020, we completed 750 inspections of centres for people with disabilities. In response to the public health emergency, the inspection process was adjusted to implement infection prevention and control measures in collaboration with public health. These measures ensured the risk of infection to residents, staff and to inspectors was minimised. Routine inspections were suspended and all inspections were scheduled on the basis of information indicating potential risk to the safety of residents.

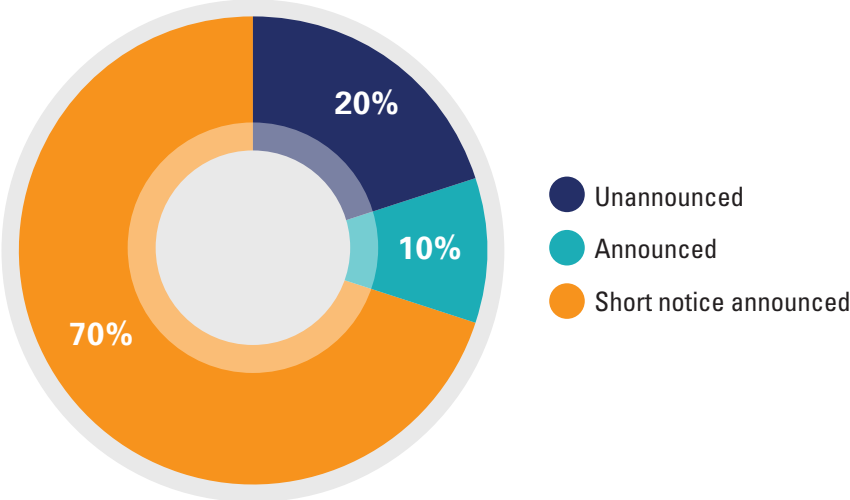
Inspections can be announced, unannounced or short notice announced<sup>12</sup> and may take place at any time of day or night. Of the 750 inspections completed, 10% were announced, 70% were short notice announced with the remaining 20% unannounced.

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11 Health Service Executive. Time to move on from congregated settings - A strategy for community inclusion. Dublin, Health Service Executive; 2011. Available online from: <https://www.hse.ie/eng/services/list/4/disability/congregatedsettings/time-to-move-on-from-congregated-settings-%E2%80%93-a-strategy-for-community-inclusion.pdf>.

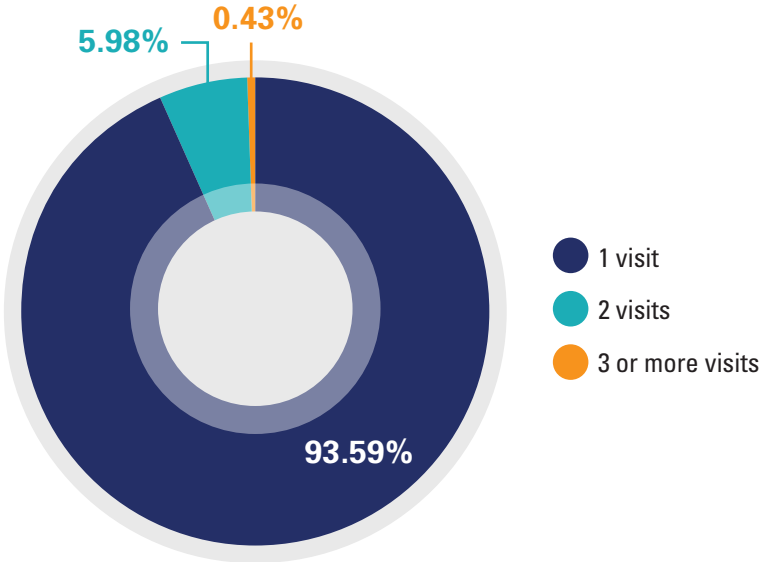
12 On March 10 2020, the Chief Inspector and HIQA issued a regulatory response to COVID-19 setting out additional precautions that were to be implemented within the inspection on monitoring processes. Read it at <https://www.hiqa.ie/hiqa-news-updates/regulatory-response-hiqa-and-chief-inspector-social-services-covid-19>.

**Figure 13 - Percentage of announced and unannounced inspections of designated centres for people with disabilities carried out in 2020**



The majority of centres (657) visited in 2020 received one inspection. This indicates that they had a good level of compliance and that, where there were non-compliances, the provider responded appropriately. While 42 centres required two inspections to monitor compliance, three centres required three or more follow-up inspections. In two<sup>13</sup> of these centres, there were significant concerns in relation to the quality of life for residents which required increased monitoring by inspectors.

**Figure 14 - Percentage of inspection visits per centre inspected in 2020**



13 One centre had two site visits as part of its registration due to the provider changing the intended purpose of the centre from adults to children prior to being registered.

In addition, from the onset of the COVID-19 pandemic, inspectors undertook a programme of quality assurance calls to assess providers' capacity and preparedness for responding to an outbreak of COVID-19 in each centre. Between April and August 2020, each designated centre was contacted, initially on a two-weekly basis. During this period, a total of 7,116 COVID-19 quality assurance calls were completed.

In the majority of centres (428) inspected between May and December 2020, inspectors found good evidence of effective infection prevention and control measures. They observed appropriate use of PPE, hand washing and social distancing.

In 50 centres, providers had COVID-19 management plans, but improvements were required to ensure full compliance with the regulations and *National Standards for infection prevention and control in community services*.

However, in 26 centres inspectors found poor infection prevention and control measures which increased the risk of infection to residents and staff. Inspectors required those providers to implement appropriate infection control measures to ensure the safety of residents as a matter of urgency.

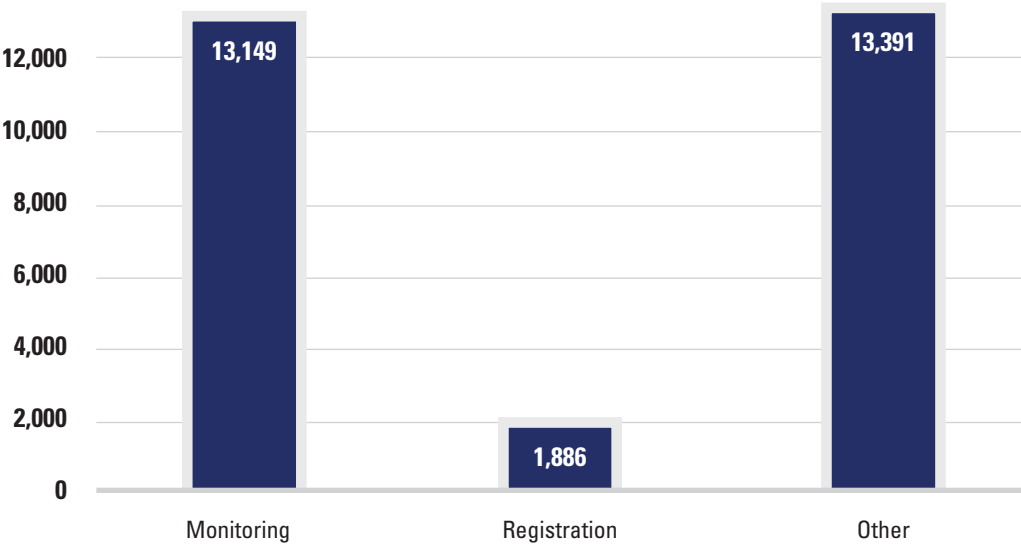
Given the significantly greater impact of COVID-19 infection in nursing homes, inspectors of disability services also assisted in the inspection programme of older persons' services and the Infection Prevention and Control Hub which provided advice to providers and staff in designated centres.



### Receipt of information

Providers or persons in charge are required to submit notifications of significant events that occur in a centre within three days, and to notify the Chief Inspector of other specific matters in the centre on a quarterly basis. These notifications are risk assessed and inform our regulatory actions. During 2020, we received 28,426 notifications relating to services for people with disabilities.

**Figure 15 - Regulatory notifications received from services for people with disabilities in 2020**



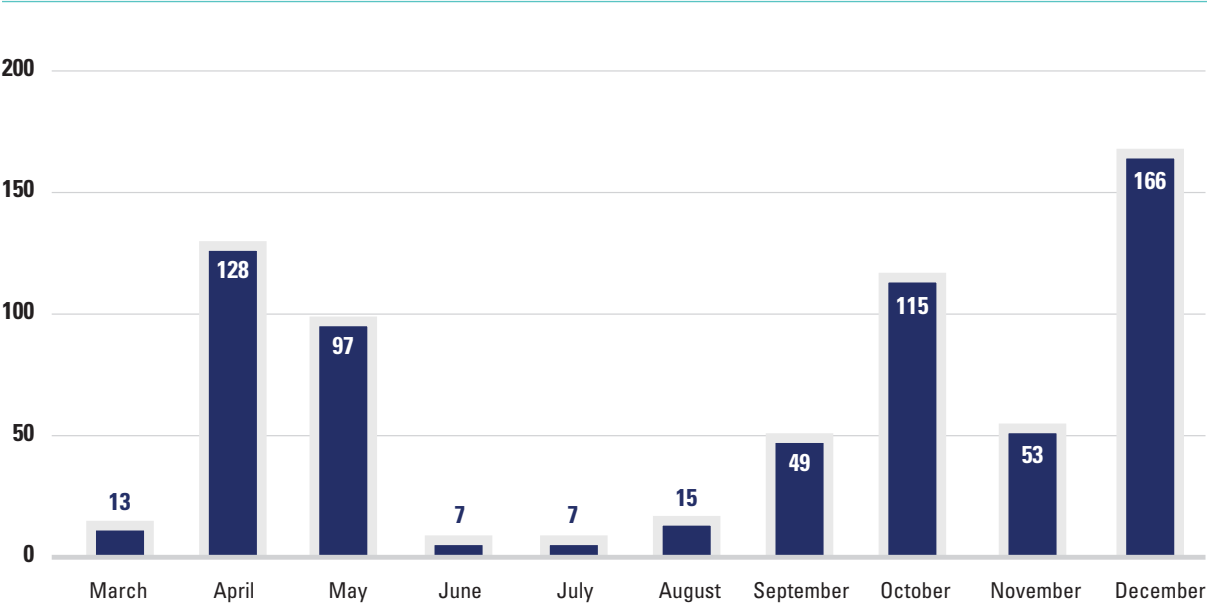
We also receive concerns about services from members of the public and other sources. Unsolicited information is provided to us by members of the public who have a concern or an issue with the care provided to residents. This information is used to support our inspection programme. We received 262 concerns about disability services in 2020.

### Notifications of COVID-19 in centres for persons with disabilities

Registered providers are required to notify the Chief Inspector of any outbreak of infectious disease in a centre. In the context of COVID-19, the Chief Inspector required providers to submit notifications when one or more residents or staff member is suspected or confirmed to have COVID-19.<sup>14</sup>

The first case of COVID-19 in a designated centre for people with disabilities was notified to HIQA on 23 March 2020. By 31 December 2020, 3,924 notifications were received where centres had suspected or confirmed cases of COVID-19, including 650 notifications of confirmed COVID-19. Figure 16 provides information on the notifications relating to confirmed instances of COVID-19 infection.

**Figure 16 - Number of notifications received from March to December 2020 reporting a resident or staff member with confirmed COVID-19**

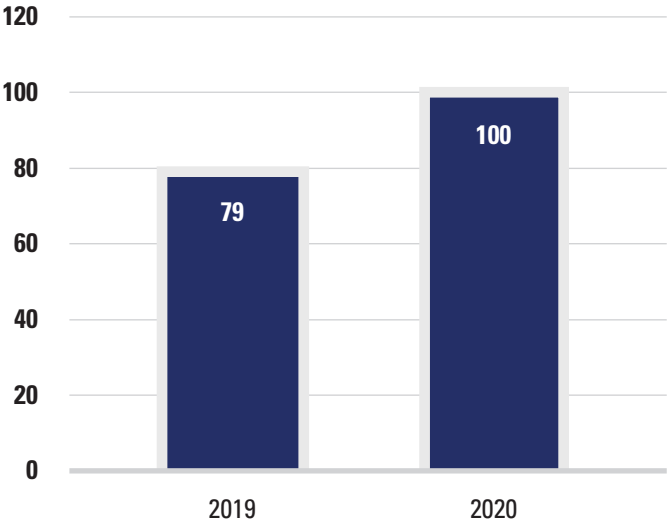


<sup>14</sup> On 20 April 2020, the Chief Inspector issued a regulatory notice regarding an enhanced portal (online) notification form to facilitate the provider’s regulatory obligation to notify the Chief Inspector of any outbreak of any notifiable disease and ensure regulatory oversight.

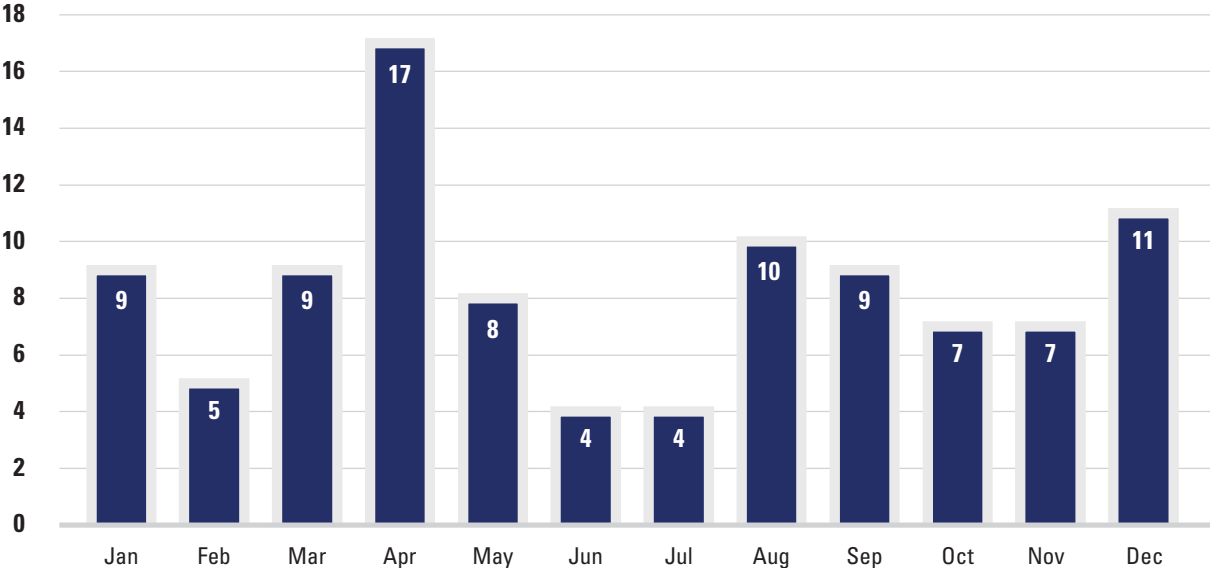
When a notification of COVID-19 is received, we review, risk rate and close the risk where no outbreak is detected or when the outbreak at the centre is over, in line with public health advice.

In addition to notifying the Chief Inspector of confirmed or suspected incidences of COVID-19 infection, registered providers are required to inform the Chief Inspector about unexpected deaths in their centres. A review of the number of deaths reported to the Chief Inspector in 2020 compared to 2019 shows an increase of 21 unexpected deaths in centres for people with disabilities.

**Figure 17 - Notifications of an unexpected death in 2020 compared to 2019**



**Figure 18 - Notifications of an unexpected death received between January and December 2020**



## Stakeholder engagement

In 2020, we published the findings of our 2019 programme of resident engagement. The report outlines what residents of disability services told HIQA about their lives, experiences and the inspection process. It also highlights examples of what residents told inspectors about their rights, their home, their community and the people that are most important in their lives.

During 2020, and in response to COVID-19, our face-to-face programme of engagement with residents was postponed. However, in August 2020 a working group began developing a pilot using video conferencing technology to support online resident engagement sessions.

Listening to and observing the experience of residents, particularly during the pandemic, and in light of national restrictions, remained a core element of our inspection processes. During each inspection, inspectors endeavour to talk to, observe and communicate with residents, while observing all recommended public health advice.

The majority of residents were able to speak with inspectors about the national restrictions and why they were necessary. They often spoke about the impact of the restrictions on their lives and how much they missed their family or friends and were looking forward to being able to see them again in the future.

In previous years, the Deputy Chief Inspector has chaired a quarterly provider representative forum meeting to ensure effective communication between the regulator and providers. These meetings include representatives from the National Federation of Voluntary Service Providers, Disability Federation of Ireland, the Not for Profit Business Alliance and the HSE in their role as service provider. Due to the national situation, we met twice in May and then continued to meet monthly since June 2020. These meetings have provided a valuable opportunity for providers of services to update HIQA on any emerging issues related to the pandemic, and for HIQA to provide regular updates on any regulatory matters.



### 4.1.3 Provision of an assurance and regulation programme of the quality and safety of defined children’s social care services in Ireland

Our Children’s Team monitors and inspects a range of services provided to children by statutory and non-statutory providers. These services include:

- children’s residential centres (statutory)
- foster care (statutory and private)
- special care units (statutory designated centres)
- Oberstown Children Detention Campus
- child protection and welfare services (statutory).

Each service has its own statutory framework that gives HIQA the authority to monitor and inspect the service, using standards and or regulations which set out what is expected from the service.

Regulatory activity carried out by the Children’s Team in 2020 included:

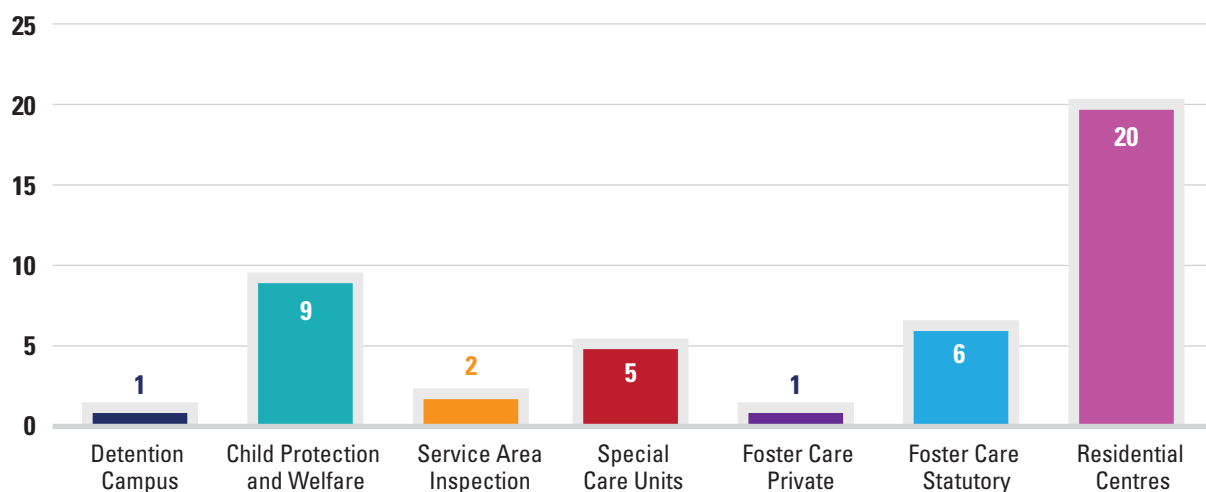
- Inspections of 20 statutory residential centres for children against the *National Standards for Children’s Residential Centres*. Five of these were unannounced inspections, with a short notice announcement<sup>15</sup> provided to the remaining centres. These inspections included 19 full inspections and one follow-up inspection.
- Five inspections of the three special care units took place during 2020. Three were announced routine monitoring inspections. These inspections focused on regulations related to governance and management, including staffing resources, planning for children, risk management and safeguarding. Two inspections of one special care unit were carried out in response to specific risks (one inspection was unannounced).
- Six announced inspections of statutory foster care were carried out to complete a focused programme of inspection that commenced in 2019. This programme examined the arrangements in place for the assessment of children and young people, care planning and review, preparation for leaving care, safeguarding and child protection, and matching foster carers with children and young people. Inspections also examined the role of social workers.
- One announced inspection was carried out of a private foster care service to examine management arrangements, child protection and welfare, and the recruitment, assessment, approval, supervision and review arrangements in place for foster carers.

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15 Services were notified 72 hours in advance of inspection.

- One annual announced inspection was carried out of Oberstown Children Detention Campus.
- Seven thematic announced inspections of child protection and welfare services were completed. This programme commenced in 2019 and its objective was to promote improvement in the management of referrals from screening and preliminary enquiry, safety planning and initial assessments.
- Two risk-based child protection and welfare inspections of the child protection notification system were completed. One was a follow-up inspection. The inspections examined the management of children on the child protection notification system and the governance of the service.
- Two risk-based service area inspections were completed. These inspections focused on specific risks in both the child protection and welfare and foster care services.

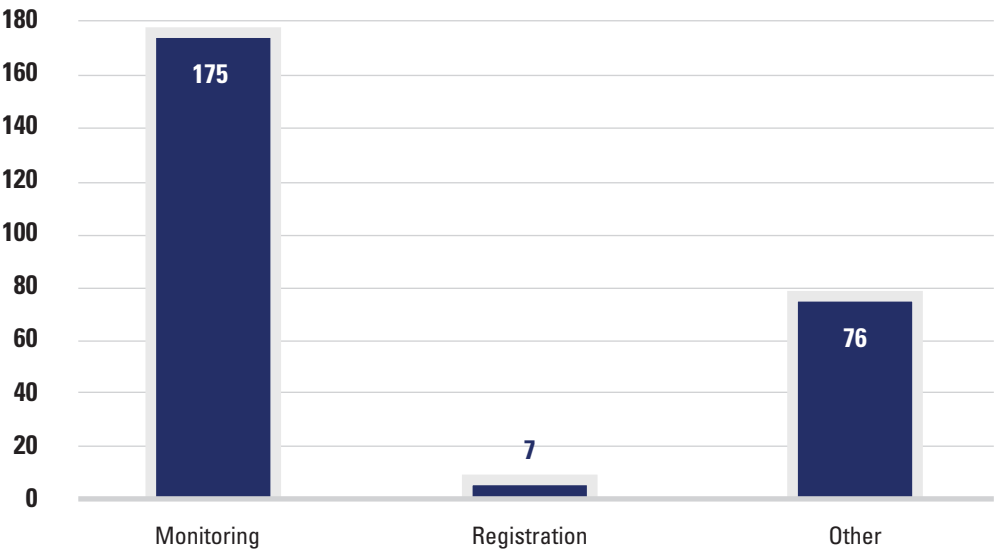
**Figure 19 – Inspections of children’s services in 2020**




During 2020, HIQA's Children's Team:

- received 44 notifications from Tusla (the Child and Family Agency). Tusla is required to notify us of any deaths and serious incidents involving children in care and children known to the child protection and welfare service. All information received was assessed and risk rated and used to inform our monitoring programme.
- received four National Review Panel reports relating to serious incidents and deaths involving children in care and or children known to the child protection and welfare service.
- received 71 pieces of unsolicited information from children who use services, their families, foster carers, staff and members of the public, compared to 79 pieces of information received in 2019. Of the 71 pieces of information received, 34 (48%) related to child protection and welfare services, 33 (46%) related to foster care services, two (3%) related to children's statutory residential centres and two (3%) to special care units. The main themes of the information received included Tusla's management of safeguarding and child protection concerns, complaints management, family contact, poor communication, care planning for children in care and children's rights being upheld.
- received 258 notifications from special care units, including 175 monitoring notifications, seven registration notifications and 76 others.

**Figure 20 - Regulatory notifications received from special care units in 2020**





In addition to the above inspections, our regulatory programme also included the following:

- In March 2020, due to the COVID-19 pandemic inspections of children's services were confined to risk-based inspections. A quality assurance process was set up with all services which involved inspectors regularly contacting Tusla, child protection and welfare services, foster care services, residential care centres, special care units and Oberstown Children Detention Campus by phone to provide support and monitor the preparedness of services for an outbreak of COVID-19, and its potential impact on service delivery to children.
- Inspectors made direct contact by telephone with 72<sup>16</sup> children placed across 39 statutory children's residential centres and three special care units, over a two week period in early May 2020. Overall, this consultation process highlighted that children were generally satisfied with efforts being made to ensure they maintained contact with the important people in their lives and their social workers. Children also said that they had ongoing support from staff to stay engaged with their education and to have their health and wellbeing needs met. It was evident that children were fully aware of COVID-19 and the risk it posed to them and the people around them. Some children described feeling very anxious during this time. These findings were consistent with what managers of these services were reporting to inspectors through the monitoring systems put in place for these services during the same period.
- During May 2020, we organised a competition for children placed in statutory residential and secure care settings inspected and or regulated by HIQA, inviting them to tell us about how they were being creative or had shown or experienced kindness during the COVID-19 pandemic. Entries were received from children placed in statutory children's residential centres across all four Tusla regions, all three special care units, and Oberstown Children Detention Campus. Children showcased the quality and breadth of their talents, including storytelling, poetry, drawings and undertaking complex projects. Significantly, entries showed how aware children were of the risks of COVID-19 and how to keep themselves safe. Together with the services these children were placed in, we were touched by the level of compassion shown by children towards others during this difficult time, and the lengths they went to express their thoughtfulness towards the people they cared for, and the elderly in their local communities. All children who took part received a prize.

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16 58 out of 114 children placed in statutory children's residential centres, and 14 out of 17 children placed across three special care units at that time.



*A selection of the competition entries*

- Routine inspections re-commenced in July 2020. Since then, we have continued to operate a quality assurance process by having regular contact with the managers of children’s residential centres and Oberstown Children Detention Campus. This process involved inspectors contacting each service on a monthly basis in order to provide support, give information on infection prevention and control, and discuss strategies that were in place to prevent interruptions to service delivery to children.
- We completed a literature review to inform the design and development of methodology for a thematic foster care inspection programme.

## Stakeholder engagement

During 2020, while the COVID-19 pandemic impacted some stakeholder engagement opportunities, we continued to engage with children, services and Tusla.

We are committed to promoting and reflecting the voice of children and young people in our work. We actively encourage and facilitate children and young people that we meet over the course of our work to participate in inspections.

Through this consultation process, we can capture children's lived experience of their care, and understand better the impact of the governance of these services on these experiences. A particular focus of participation of children and young people in our work is to capture how they are involved in decision-making on issues that affect them. Such decision-making is enshrined in the Irish Constitution and Article 12 of the United Nations Convention on the Rights of the Child (UN, 1989), ratified by Ireland in 1992.

Over the course of inspections in 2020, we engaged with a total of 1,041 children, 914 of whom were in foster care, 60 in statutory children's residential centres, 13 in special care units, and 11 in Oberstown Children Detention Campus. We also made contact with 43 children receiving a child protection and welfare service from Tusla. Children spoke directly with inspectors or completed and returned questionnaires describing their experience of the service. Inspectors also met with or spoke with parents and foster carers as part of our inspection activity.

The Director of Regulation and the Children's Head of Programme met with the Assistant Secretary, Child Policy and Tusla Governance Division of the Department of Children, Equality, Disability, Integration and Youth during 2020 to exchange relevant updates and exchange information on actual or potential risk across the sector and discuss progress on regulatory developments. A representative from the Children's Team is also a member of a working group chaired by the Department of Children, Equality, Disability, Integration and Youth in relation to the single allocation of social workers in foster care.

Throughout 2020, we held regular meetings with Tusla's senior management team to share information such as on regulatory developments, risks, practice issues and service delivery. Other stakeholders engaged with in 2020 included the Chairperson of the Board and Campus Director of Oberstown Children Detention Campus.

#### 4.1.4 Healthcare services

Under the Health Act 2007, as amended, HIQA is responsible for monitoring compliance in healthcare services. We also investigate the safety, quality and standards of healthcare services where there is a serious risk to the health and welfare of patients, in line with the Health Act. As part of its regulatory function, HIQA is also the Competent Authority in Ireland with responsibility for regulating medical exposure to ionising radiation.

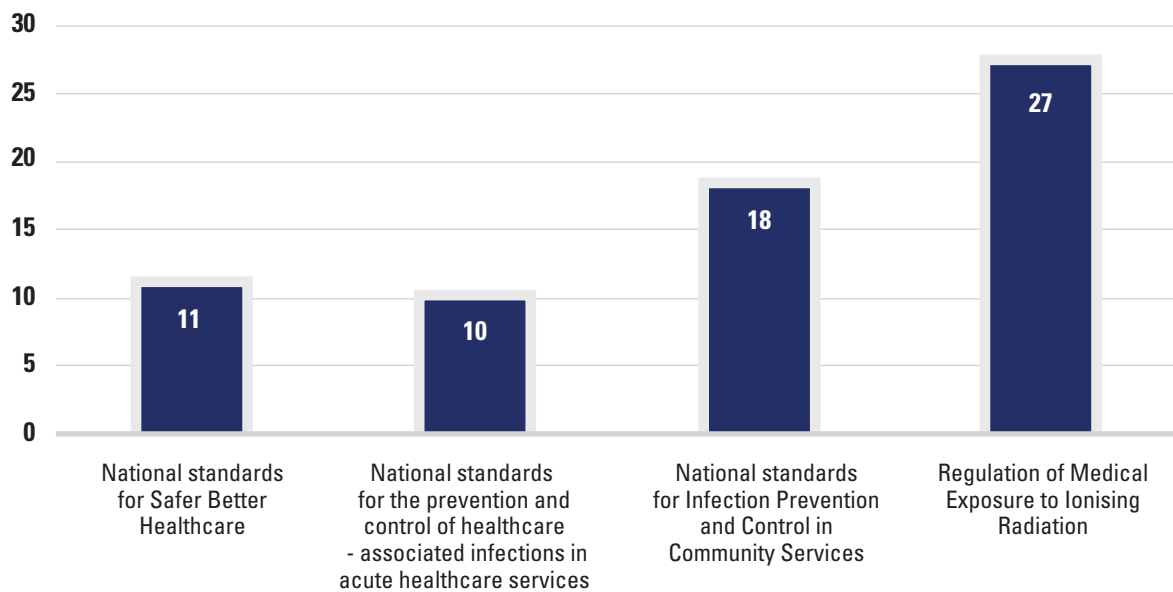
In 2020, we carried out 66 inspections of healthcare services. These included:

- 11 inspections as part of monitoring programmes against the *National Standards for Safer Better Healthcare*. Of these inspections, four were completed to monitor medication safety in public acute hospitals — a programme of inspections ongoing since 2017. The remaining seven were completed as part of a programme of monitoring rehabilitation and community and inpatient healthcare services. This programme, which began in 2019, took a particular focus on governance and risk management structures, and measures in particular to ensure the prevention and control of healthcare-associated inspections and the safe use of medicines.
- 18 inspections against the *National Standards for infection prevention and control in community services*. In response to the COVID-19 pandemic, we commenced a new targeted inspection approach of infection prevention and control in rehabilitation and community inpatient healthcare services in July 2020. These inspections assessed compliance against specific national standards for infection prevention and control, with a particular focus on the ongoing COVID-19 pandemic and its management.
- 10 inspections against the *National Standards for the Prevention and Control of Healthcare-associated Infections in Acute Healthcare Services*. In response to the COVID-19 pandemic, we began a focused programme of monitoring compliance with specific national standards for infection prevention and control in acute hospitals in September 2020. This programme was designed to take account of specific standards of direct relevance to managing risks posed by COVID-19 in this setting.
- 27 inspections of public and private radiological facilities encompassing medical and dental X-ray services as part of our role in regulating medical exposure to ionising radiation. These inspections were prioritised based on a risk-based approach. We also conducted the first five inspections of the dental sector in the final quarter of 2020, following an online stakeholder engagement campaign. These inspections were prioritised for services providing cone beam computed tomography (CBCT).<sup>17</sup>

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17 Cone beam computed tomography (CBCT) is a technique for imaging the body in thin sections or slices using specialised computers and imaging equipment.

**Figure 21 - Number of healthcare services inspections conducted in 2020**



In addition to the above inspections, our monitoring programme included the following:

- We received 293 pieces of unsolicited information from the public during the year relating to healthcare services. This information was used to further support our monitoring programme.
- We received 20 requests for information. Eight of these related to queries on infection prevention and control and COVID-19.
- In February 2020, HIQA published an *Overview report of HIQA's monitoring programme against the National Standards for Safer Better Maternity Services, with a focus on obstetric emergencies*. The report, which was published alongside 19 individual inspection reports from each service nationally, outlined a summary of findings from each inspection, coupled with an overview of the national picture relating to this area of service provision. HIQA made eight recommendations to the HSE to improve the quality and safety of maternity services into the future, including the development of a comprehensive plan to fully implement both the *National Standards for Safer Better Maternity Services* and the National Maternity Strategy.



- In August 2020, we published a *Five year overview of healthcare monitoring 2015-2019* which provided an analysis of our monitoring work in healthcare services over that period. The report identified areas of progress and further opportunities for improving the quality and safety of services of care, including: the need to address significant variation between hospitals to meet national standards, to strengthen and formalise access to specialist infection control expertise in rehabilitation and community services; and the need to progress enactment of the Patient Safety Bill to extend HIQA's role in monitoring public and private healthcare services.
- We reviewed and assessed 77 statutory notifications of significant events of accidental and unintended exposures to ionising radiation, and subsequent reports on the outcomes and actions taken to mitigate reoccurrence. Furthermore, we published the first *Overview report on significant events of medical exposure to ionising radiation 2019*. The report presented an overview of the findings from notifications received as part of HIQA's regulatory function with the aim of sharing the learning from these investigations.
- We commenced HIQA's first review of general X-ray, mammography and dual-energy X-ray absorptiometry (DXA or DEXA)<sup>18</sup> imaging doses. This was required as part of our Competent Authority function to review national diagnostic reference levels or typical doses service users should receive as part of their diagnosis. We issued a diagnostic reference level survey tool to over 130 undertakings and reviewed the responses. The results of this survey will be published in 2021.
- To further aid national efforts in addressing COVID-19 and given HIQA's significant level of experience in inspecting hospitals against the *National Standards for the Prevention and Control of Healthcare-Associated Infection in Acute Hospitals*, in April 2020 the National Public Health Emergency Team (NPHET) requested that HIQA provide a desktop evaluation of infection prevention and control preparedness relating to COVID-19 in public acute hospitals. The report was informed through a self-assessment exercise conducted by hospital groups, allied to HIQA's own information gained through inspection activity over recent years.

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18 Dual-energy X-ray absorptiometry (DXA or DEXA) is a type of low dose medical exposure generally used to assess bone density in service users where low bone density or osteoporosis is suspected.

## Stakeholder engagement

Despite the impact of COVID-19 on the ability to conduct face-to-face stakeholder meetings in 2020, stakeholder engagement was progressed in a number of areas.

We continued to engage with colleagues in the Department of Health and other stakeholders to prepare for the passing of the Patient Safety (Notifications) Bill into law. Such engagement was accompanied by a body of internal preparatory work, which included a review of our monitoring approach to national standards. Further engagement with stakeholders related to any changes that may result from this review process, and in contemplation of this new legislation, is intended in 2021.

Regarding our ionising radiation regulatory role, we continued to meet with key stakeholders, including the HSE's Radiation Protection Office and representatives of the Dental Council. A Memorandum of Understanding was signed with the Environmental Protection Agency and continued engagement took place with virtual meetings in 2020 on our regulatory interface.



*Director General of the Environmental Protection Agency, Laura Burke, and our CEO, Phelim Quinn, pictured signing a memorandum of understanding.*

In advance of commencing inspections in the dental sector in the area of radiation protection, two webinars were hosted to provide information about HIQA's monitoring approach for the regulation of dental services providing medical exposure to ionising radiation.

These webinars provided guidance for dental undertakings, and interested stakeholders, relating to:

- a self-assessment questionnaire and how it is to be completed
- the format of HIQA's on-site inspections.

These proved to very successful with nearly 590 attendees across the two sessions, with over 190 questions answered during the live questions and answers session.

HIQA's Expert Advisory Group for medical exposure to ionising radiation, which facilitates consultation on our Competent Authority functions, met virtually in September 2020. Furthermore, we continue to be represented in Europe at the Heads of European Radiological Competent Authority (HERCA) regulators forum which met virtually in September 2020.



*These proved to very successful with nearly 590 attendees across the two sessions, with over 190 questions answered during the live questions and answers session.*

### 4.1.5 COVID-19 supports for services and regulatory reform

In the early stages of the COVID-19 pandemic, the Chief Inspector was actively monitoring the developing situation in the context of health and social care services. At the time, it was known that the disease presented a greater risk to the elderly and people with underlying health conditions. As such, there was a heightened awareness around the potential for COVID-19 to emerge in nursing homes and residential disability services.

Inspection staff continued to monitor services, including reports of any outbreaks of disease or increases in deaths. The developing situation in the country as a whole was deteriorating and a decision was made to suspend all routine inspections on 12 March 2020. This was to ensure that inspectors did not contribute to the spread of disease in designated centres.

Throughout this time, the CEO, as a member of NPHE, and the Chief Inspector were in contact with officials in the Department of Health, the HSE and other stakeholders to ensure effective lines of communication in terms of reporting and monitoring outbreaks and their impacts, as well as escalating concerns around PPE or staff shortages in centres, and advice or support for infection control.

#### Regulatory notices

Regulatory notices were issued to centres which specified the need for accurate and timely data around suspected or confirmed outbreaks of COVID-19. From March to December 2020, we issued 43 communications related to COVID-19 to services directly from the Chief Inspector and on behalf of Department of Health, HSE, Nursing Homes Expert Panel and National Advocacy Service.

In summary, these notices included information on:

- reducing the number of mandatory notifications to be submitted and facilitating an easier system to ensure the timely return of data on the number of residents and staff with suspected or confirmed cases of COVID-19, and the number of unexpected deaths in each centre.
- advising providers of the facility of a one-day turn around registration process to expedite the opening of new residential beds
- guidance for providers on the key contingency structures and processes that each provider should have in place in to effectively manage a suspected and or confirmed case of COVID-19.
- the establishment of the Infection Prevention and Control Hub.

## Infection Prevention and Control Hub

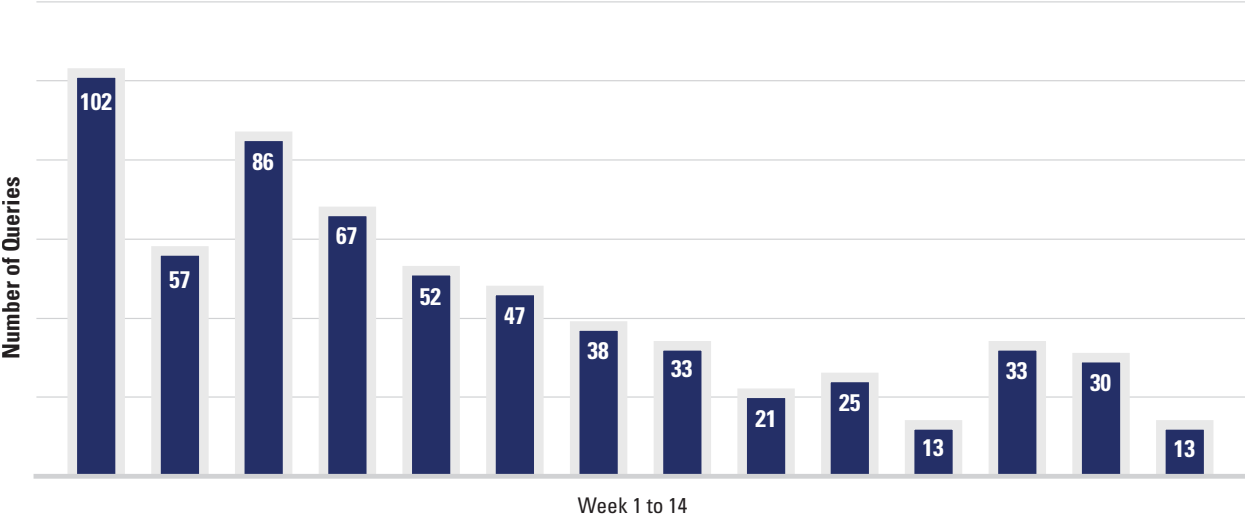
HIQA established an Infection Prevention and Control Hub on 6 April 2020 as a source of immediate advice and support to providers of designated centres. The Hub was staffed by HIQA inspectors with extensive experience in infection prevention and control.

The Hub offered support, guidance and training including on:

- outbreak preparedness
- outbreak management advice (for example, resident placement, cohorting and special measures where isolation is not possible, transmission and standard precautions)
- understanding HSE advice and its applicability to specific centres
- general support on infection control issues.

Advice was offered via a dedicated email and phone line. Between 6 April 2020 and 10 July 2020 the Hub managed and responded to 617 infection prevention and control queries. The dedicated email address (DCIPCsupport@hiqa.ie) continues to be available for queries; however, these reduced significantly in numbers in the latter six months of 2020.

Figure 22 - Infection Prevention and Control Hub queries



## **Assessment framework of the preparedness of a centre for a COVID-19 outbreak**

In April 2020, HIQA published an *Assessment framework of the preparedness of a centre for a COVID-19 outbreak in older person's designated centres*. The framework aimed to support centres that were free from COVID-19 to prepare for an outbreak and put the necessary contingency plans in place. Through a process of self-assessment, a provider could:

- assess the centre's preparedness to manage an outbreak of COVID-19 under key governance, leadership, management and quality and safety regulations
- assess their knowledge of the resources available to support residents and staff in preparing for and managing an outbreak
- access specialist clinical advice in providing safe care for residents
- assess the systems in place to ensure the centre is a safe place for residents.

Inspections recommenced in April to validate providers' self-assessments through on-site interviews with the registered provider or their representative, and a review of documentation and observation. In preparation for this, inspectors underwent training in the HPSC guidance and the proper use of PPE. A total of 189 such assessments were undertaken between 29 April and 26 May, through on-site inspections and by telephone.

## **Assurance framework for registered providers - preparedness planning and infection prevention and control measures**

In September 2020, HIQA published a COVID-19 assurance framework to support social care services in ensuring effective infection prevention and control practices are in place.

This framework was developed using the *National Standards for Infection Prevention and Control in Community Services* (2018). It focuses on the national standards, providing a tool to enable providers to tailor their approach to meeting national standards effectively in their centre. It does this by focusing on the critical aspects of care to ensure the efficacy of:

- infection prevention and control governance and management arrangements
- preparedness and contingency plans
- staffing arrangements
- the knowledge and confidence of staff in care services in implementing infection prevention and control measures and audit and review arrangements.

The framework consists of a guidance document, self-assessment tool and quality improvement plan. It aims to give providers and their management teams the necessary tools to enable them to identify good practice and areas of improvement, and take the necessary action to address any gaps or deficits in their centres.

To support providers to implement the framework, we ran four webinars in October 2020 for providers and managers of designated centres. The sessions were attended by 1,450 participants. A video resource was also developed to support providers to implement the framework.

### **Suggested interim amendments to the Health Act 2007**

COVID-19 and its impact on centres for older people and people with disabilities identified opportunities to enhance the Health Act 2007, as amended, and the regulations. The rigidity of some aspects of the Act and regulations as currently written created significant challenges for the Chief Inspector to effectively respond in a timely manner to the evolving situation. Many of the changes implemented as a result of the challenges COVID-19 presented, relied on the cooperation of registered providers and staff in centres, for example changes to the mandatory notification of suspected and confirmed cases of COVID-19 in designated centres.

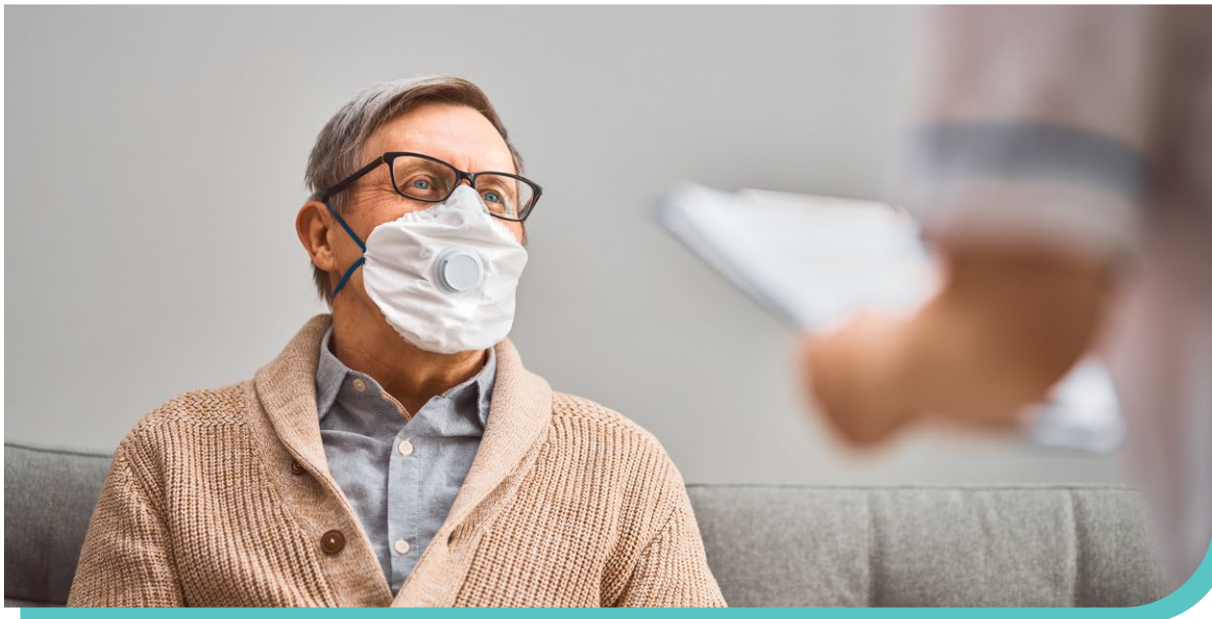
In June 2020, HIQA submitted a paper to the Minister for Health which focused on the immediate changes required to the Act and regulations to help sustainably deliver a quality service to residents during the public health emergency. These changes also would help to ensure that registered providers can detect, manage and respond in a sustainable way to the risk of further outbreaks of COVID-19 or indeed another such health emergency. In addition, the changes would allow the Chief Inspector hold registered providers to account and expedite any regulatory actions as appropriate.

## COVID-19 Nursing Home Expert Panel

The COVID-19 Nursing Home Expert Panel report was published in August 2020. It contains 86 recommendations grouped into 15 thematic areas. Each recommendation has an associated timeline for implementation. HIQA is represented as part of the membership of the report's Implementation Oversight Team which is chaired by the Department of Health.

Of the 86 recommendations, 31 include HIQA as a lead organisation or with a compliance oversight role. To date, HIQA on behalf of the Department of Health has facilitated two surveys, one related to the recommendations for which the provider is responsible and one staffing survey.

A significant number of recommendations require changes to the Health Act 2007, as amended, and or statutory regulations. HIQA is represented on a bi-lateral group chaired by the Department of Health examining the changes required as a result of the report. A paper submitted to the Minister for Health in June 2020 on *Suggested interim amendments to the Health Act 2007 as amended and the regulations for designated centres for older people and adults and children with a disability* is also before this group for consideration.





## **Regulatory reform**

In addition to responding to the immediate impact of COVID-19 in health and social care services, HIQA took account of how the existing regulatory framework was affecting the capacity to respond. It became increasingly evident that clinical governance and oversight in private and voluntary nursing homes was not at the same level as found in statutory nursing homes. Similarly, some regulations, particularly those pertaining to governance and infection prevention and control were considered to be in need of review and updating. Cognisant of these concerns, the learning from the COVID-19 pandemic and from regulatory social care services over the last 11 years, we have drafted a paper on regulatory reform. The paper summarises a number of existing papers and evidence on regulation, and sought to make an argument for the need to reform the entire system of regulating social care services. It is hoped that this will contribute to the wider debate around reforming Ireland's health system in the context of Sláintecare. The paper is due for publication in early 2021.

## **LENS Project (LEarning from Statutory Notifications in Social Care)**

In 2019, HIQA was awarded €250,000 in funding from the Health Research Board under the Secondary Data Analysis Project Grant. This project aimed to learn from the statutory notifications HIQA received from designated centres.

In 2020, we extracted and compiled statutory notification data received by HIQA from 2013 to 2019 into an analysable database: Database of Statutory Notifications from Social Care, 2013-2019. The data were primarily retrieved from HIQA's IT system and supplemented with additional data from designated centres' statement of purpose documents. Other variables were generated by combining or editing existing data.

In order to make this information available to the public, the Database of Statutory Notifications from Social Care, 2013-2019 was assessed to determine what information could be made available for the open access version of the dataset. In accordance with privacy and data protection concerns, we removed or anonymised any information that may identify an individual centre or resident. The output of this process is the open access version of the dataset; Database of Statutory Notifications from Social Care, 2013-2019 (Open Access) which will be made publicly available in early 2021, and will be updated on a yearly basis. A number of support tools will also be made available to users of the databases including a data dictionary, data map, e-learning module, tableau for visualisations and a data quality statement. The database is being made publicly available to promote secondary analyses of the data that may inform policy, practice and innovation in the care for older persons and people with disabilities.

## 4.2 Health technology assessment and evidence synthesis

Under the Health Act 2007, HIQA has a statutory role to evaluate the clinical and cost-effectiveness of health technologies and to provide advice to the Minister for Health and the HSE in this regard. This is called health technology assessment (HTA), and it informs investment decisions in health and social care. We also conduct evidence synthesis to support the development of national clinical guidelines and national clinical audit, as well as to inform the development of health policy. We develop national guidelines to inform the production of timely, consistent and reliable assessments that are relevant to the needs of people using health and social care services.

HIQA's Corporate Plan 2019-2021 includes two strategic objectives:

- To produce high-quality health technology assessments (HTAs) and other evidence synthesis to inform major health-policy and health-service decisions, including national clinical guidelines and national clinical audit.
- To expand and consolidate capacity to conduct and use evidence synthesis and knowledge generation, both in HIQA and across the health system.

In 2020, HIQA also took on a key role in providing evidence synthesis to inform public health decision-making in relation to COVID-19.



### 4.2.1 COVID-19 evidence synthesis and advice


COVID-19 is a new disease and the evidence and information about it continues to rapidly evolve since its emergence in December 2019. HIQA began to provide evidence synthesis to support the national public health response to the COVID-19 pandemic in March 2020 at the request of the Department of Health.

A COVID-19 Evidence Synthesis Team was established in HIQA's HTA Directorate to provide evidence synthesis to support the work of the National Public Health Emergency Team (NPHE), NPHE sub-groups and other groups in the Department of Health and HSE working on the national public health response. Members of HIQA's Health Information and Standards Directorate and colleagues from the HRB Centre for Primary Care Research (HRB-CPCR) in the Royal College of Surgeons in Ireland (RCSI) provided additional capacity to the team.

Members of the team also participated in the NPHE Subgroup on Guidance and Evidence Synthesis which was chaired by the Director of HTA, Dr Máirín Ryan. Dr Ryan and our Chief Scientist, Dr Conor Teljeur, are members of NPHE's Irish Expert Modelling Advisory Group (IEMAG). The Deputy Director of HTA, Dr Patricia Harrington, is a member of the HSE Rapid Antigen Diagnostic Testing working group.

In September 2020, HIQA commenced providing evidence-based advice directly to NPHE on behalf of the Minister for Health. The advice is informed by evidence synthesis undertaken across all relevant domains of HTA and health services research. We established a COVID-19 Expert Advisory Group (EAG) to provide expert interpretation of the relevant evidence and inform the development of the advice to NPHE. The EAG comprises nominated representatives from the relevant clinical and public health stakeholder groups, patient representation and methodological expertise.

Overall, from March until December 2020, we produced 49 different evidence synthesis outputs, a number of which were regularly updated as new evidence emerged. These included six reviews of public health guidance (65 versions in total), 22 evidence summaries (40 separate versions), six advice reports to NPHE, six reports looking at care pathways, two rapid HTAs, three pieces of analysis or modelling (eight separate updates), two scoping HTAs, a regularly updated database of international public health guidance (166 updates) and a review of policy measures to limit the spread of COVID-19 (updated 28 times).



The evidence synthesis reports compiled in response to specific requests from NPHET, its subgroups, the Department of Health, HSE and HPSC between March and September 2020 included:

- evidence summaries provided to the NPHET Expert Advisory Group on:
  - the potential for children to contribute to transmission of SARS-CoV-2
  - the relative importance of droplet versus contact transmission to the spread of SARS-CoV-2
  - airborne transmission of SARS-CoV-2 via aerosols
  - accuracy of salivary samples in SARS-CoV-2 detection compared with nasopharyngeal, oropharyngeal or lower respiratory tract samples
  - the accuracy of molecular and antigen detection tests for the diagnosis of COVID-19 using alternate clinical specimens or sites
  - facemask use by healthy people in the community
  - universal facemask use by healthcare workers in the context of COVID-19
  - the immune response following infection with SARS-CoV-2 or other human coronaviruses
  - non-contact thermal screening as an effective means of identifying cases of COVID-19
  - the risk of transmission of SARS-CoV-2 during aerosol generating procedures from patients without clinical symptoms
  - surgical outcomes in patients with COVID-19
  - SARS-CoV-2 viral load and infectivity over the course of an infection
  - placental transfer of antibodies
  - average length of stay in the intensive care unit for COVID-19
  - asymptomatic transmission of COVID-19
  - the natural history of COVID-19 in children
  - the effectiveness of pathways to enable the resumption of hospital-based care in the context of COVID-19
  - public health guidance on identification and management of symptoms in young children and young people attending school in the context of COVID-19

- a rapid HTA of alternative diagnostic testing approaches for the detection of severe acute respiratory syndrome (SARS-CoV-2) provided to NPHEA
- a scoping HTA on universal influenza vaccination in children provided to the Department of Health
- international reviews of public health measures and strategies including:
  - public health guidance on universal face mask use by healthcare workers in the context of COVID-19
  - public health guidance on physical distancing in the context of COVID-19
  - public health guidance for residential care facilities in the context of COVID-19
  - public health guidance on protective measures for vulnerable groups in the context of COVID-19
  - international public policy responses to easing restrictions introduced to limit the spread of COVID-19
- epidemiological analysis of excess mortality
- evidence syntheses to the National Ambulance Service including a:
  - review of the operation of emergency medical dispatch centres, guidance for pre-hospital emergency services and patient transport services
  - database of guidance for pre-hospital emergency services and patient transport services in the context of COVID-19
- database of international public health measures provided to the Department of Health and the HPSC daily.

Evidence syntheses conducted since September 2020 include:

- evidence summaries to inform advice to NPHE on:
  - factors influencing, and measures to improve, vaccination uptake
  - face mask use by healthy people in the community to reduce SARS-CoV-2 transmission
  - the categorisation of ‘extremely medically vulnerable’ groups who may be at risk of severe illness from COVID-19
  - activities or settings associated with a higher risk of SARS-CoV-2 transmission
  - reinfection and the duration of antibody responses following SARS-CoV-2 infection
  - the incubation period of COVID-19, or time to first positive test, in individuals exposed to SARS-CoV-2
  - recommendations from international guidance on the duration of restriction of movements
  - the duration of infectiousness in those that test positive for SARS-CoV-2 RNA.
- modelling exercises on the potential impact of different testing scenarios in close contacts
- an international review of public health measures and strategies to limit the spread of COVID-19
- international reviews of public health measures provided to the Department of Health and to the HPSC, including reviews of public health guidance:
  - for residential care facilities in the context of COVID-19
  - on protective measures for vulnerable groups in the context of COVID-19
- a rapid HTA of alternatives to laboratory-based real-time RT-PCR to diagnose current infection with SARS-CoV-2
- a scoping HTA provided to the Department of Health on convalescent plasma for the treatment of COVID-19
- database of international public health measures updated three times weekly provided to the Department of Health and the HPSC.

Eight manuscripts from this work have been accepted for publication in academic journals.

## 4.2.2 HTA

### HTA of birth cohort testing for hepatitis C

In 2019, HIQA commenced work on a HTA of offering testing for the hepatitis C virus (HCV) to people in Ireland born between 1965 and 1985. The HTA was prioritised following publication of an Irish National Clinical Guideline for Hepatitis C Screening, quality assured by the National Clinical Effectiveness Committee. The guideline included a conditional recommendation to offer one-off testing to people born between 1965 and 1985 (that is, birth cohort testing) subject to the outcome of a full HTA.

Birth cohort testing involves offering one-time testing for HCV to people born during a particular period of time. The birth cohort to be tested was identified based on national data, which indicated that the prevalence of HCV infection in Ireland is highest amongst those born between 1965 and 1985 (72.5% of cases). Unlike risk-based testing, birth cohort testing avoids the need to identify underlying risk factors as the basis for testing. Individuals identified as having chronic HCV infection would be offered potentially curative treatment thereby reducing the progression to ill health and associated healthcare costs.

The HTA aims to establish the clinical and cost-effectiveness of birth cohort testing for hepatitis C in Ireland. In addition, the assessment will estimate the budget impact of introducing a birth cohort testing programme and assess the organisational and resource implications of such a service. An expert advisory group comprising representatives from key stakeholder groups has been convened to provide advice and guidance over the course of the HTA.

A public consultation on the HTA is scheduled for early 2021 before the report is finalised and provided as advice to the Minister for Health to inform a decision on whether or not to implement birth cohort testing for hepatitis C in Ireland.



*The HTA aims to establish the clinical and cost-effectiveness of birth cohort testing for hepatitis C in Ireland.*



## **Systematic review of newer and enhanced influenza vaccines**

In September 2019, HIQA was awarded a contract to conduct a systematic review of the efficacy, effectiveness and safety of newer and enhanced seasonal influenza vaccines for the prevention of laboratory-confirmed influenza in adults. The review was commissioned by the European Centre for Disease Prevention and Control (ECDC), an agency of the European Union, and involved close collaboration with the EU/EEA National Immunisation Technical Advisory Groups.

Seasonal influenza A and B viruses circulate and cause disease in humans every year and in temperate climates winter epidemics occur yearly. Most groups for whom the seasonal influenza vaccine is recommended may annually receive either a trivalent or quadrivalent inactivated seasonal influenza vaccine, although new and enhanced seasonal influenza vaccines are starting to be used in some national seasonal influenza immunisation programmes targeting mainly vulnerable groups, such as the elderly. This review evaluated the performance of the newer and enhanced seasonal influenza vaccines compared to the standard seasonal influenza vaccines, in order to inform new vaccination strategies and public health decision-making.

The project concluded in April 2020 and the final report was published on the ECDC website in October 2020. We presented the findings of the systematic review, and recommendations for future research, to members of the immunisation expert advisory groups at the ECDC and World Health Organization (WHO) to support decision-making for the 2020-2021 influenza season and beyond. We are currently preparing manuscripts for submission to academic journals for consideration.

## **National HTA guidelines**

Since 2010, HIQA has developed and published a suite of national HTA guidelines to support the production of evaluations that are timely, reliable, consistent and relevant to the needs of decision-makers and key stakeholders. With the support of the HTA Scientific Advisory Group (which includes broad representation from key stakeholders in healthcare in Ireland), this suite of guidelines is regularly updated and expanded to meet the needs of HTA activity in Ireland. During 2020, we made a minor update to the *Guidelines for the Economic Evaluation of Health Technologies in Ireland* regarding the application of purchasing power parities to transferring costs to Ireland.



### **4.2.3 National Screening Advisory Committee (NSAC) – Evidence synthesis support**

The National Screening Advisory Committee (NSAC) was established in 2019 following a recommendation of the 2018 Scoping Inquiry into the CervicalCheck Screening Programme. The NSAC is an independent advisory committee that advises the Minister for Health and Department of Health on new proposals for and revisions to population-based screening programmes. Since 2020, we have provided evidence synthesis support to the NSAC.

The NSAC aims to establish an agreed methodology for accepting applications to consider new, or revisions to existing, population-based screening programmes in Ireland. It also aims to develop and implement a robust, inclusive and transparent evidence review process to evaluate the case for new or revisions to population-based screening programmes in Ireland. We will support the NSAC by undertaking the following reviews:

1. An international review of processes which inform policy for national screening programmes generally.
2. An international review of processes for informing changes to neonatal blood screening policy.

Progress on these supports was temporarily postponed due to the evidence synthesis support to inform the national response to COVID-19. However, these reviews recommenced in January 2021.

#### **Extended Interval Screening of the Diabetic RetinaScreen Programme in Ireland**

Diabetic retinopathy is a microvascular complication of diabetes mellitus and is a common cause of vision impairment and sight loss. Diabetic retinopathy screening programmes can prevent sight-threatening diabetic retinopathy (STDR) by timely detection and treatment of cases. Diabetic RetinaScreen is responsible for the screening and STDR treatment of all individuals aged 12 years and older with diabetes in Ireland. Annual screening of people with diabetes is current practice; however, it has been proposed that screening intervals of every two years should be introduced for those at low risk of retinopathy progression and who have demonstrated compliance with the programme, in line with international practice.

During 2020, we conducted a scoping report to provide an overview of the evidence relating to extending the screening interval for diabetic retinopathy from one to two years for those at low risk of diabetic retinopathy progression. Supported by the evidence from our scoping report, the NSAC made a recommendation to the Minister for Health for the screening interval to be extended from one to two years for these individuals.

#### 4.2.4 HRB-CICER – National clinical guideline support

In 2016, HIQA was awarded a contract for €2.25 million by the Health Research Board (HRB) to establish the HRB Collaboration in Ireland for Clinical Effectiveness Reviews (HRB-CICER). HIQA's main collaborator is the HRB Centre for Primary Care Research (HRB-CPCR) in the Royal College of Surgeons in Ireland (RCSI).

HRB-CICER aims to deliver a high-quality evidence base with regard to systematic review of clinical and cost-effectiveness and budget impact analysis to support the development of evidence-based recommendations in national clinical guidelines and national clinical audits. These guidelines and audits are quality assured by the National Clinical Effectiveness Committee (NCEC) and mandated by the Minister for Health for implementation by the HSE. The collaboration also provides training in evidence synthesis and advises the NCEC on improvements in methodological developments in evidence generation, and on research gaps in the evidence base and how they may be best addressed.

We also provide support to the NCEC through membership of the Committee and by assisting with the prioritisation and appraisal of submitted guidelines. In 2020, HIQA provided expert input to NCEC appraisal and prioritisation teams for the following guidelines and audits:

- National Perinatal Epidemiology Centre (NPEC) perinatal mortality, National Clinical Audit
- Sepsis management for adults (including maternity), National Clinical Guideline
- Diagnosis, staging and treatment of patients with rectal cancer, National Clinical Guideline
- Diagnosis, staging and treatment of patients with colon cancer, National Clinical Guideline.

#### **National clinical guideline on stratification of clinical risk in pregnancy**

To support the development of a national clinical guideline for the stratification of clinical risk in pregnancy, HRB-CICER:

- carried out a systematic review of clinical guidelines and of economic literature,
- facilitated a three-round formal consensus process using the Delphi method,
- and developed a budget impact analysis to estimate the cost of implementing the clinical recommendations.

The guideline was launched in April 2020.

## **National clinical guideline on nutrition screening and oral nutrition support for adults**

HRB-CICER undertook a systematic literature review to support the development of a national clinical guideline on nutrition screening and oral nutrition support for adults. The guideline was launched in April 2020.

## **Update to National Clinical Guideline No .1 the Irish National Early Warning System (INEWS)**

HRB-CICER supported the update to National Clinical Guideline for the Irish National Early Warning System (INEWS) by undertaking six systematic literature reviews and conducting a budget impact analysis to estimate the costs of implementing the clinical recommendations. The updated guideline was launched in September 2020. There are currently two publications in academic journals (one in press, one under review) as outputs from the guideline.



*In 2016, HIQA was awarded a contract for €2.25 million by the Health Research Board (HRB) to establish the HRB Collaboration in Ireland for Clinical Effectiveness Reviews (HRB-CICER).*



## **National clinical guideline on chronic obstructive pulmonary disease**

HRB-CICER supported the development of a national clinical guideline for the treatment and management of chronic obstructive pulmonary disease in adults. We carried out a systematic review of economic literature and conducted a budget impact analysis to estimate the costs of implementing the clinical recommendations. The guideline underwent quality assurance in November 2020 and is expected to be launched in early 2021.

### **Guideline development**

We also provided the following to guideline development groups in 2020:

- a systematic review of clinical and economic literature on interventions to improve hand hygiene adherence to support the healthcare-acquired infection guideline
- a systematic review of the prevalence of intraoperative massive haemorrhage, and a systematic review of relevant clinical guidelines to support the development of the intraoperative massive haemorrhage guideline
- expert input to the budget impact analysis of the implementation of the national clinical guideline on sepsis management.

In 2020, work began on:

- a systematic review of clinical and economic literature on single patient room accommodation compared to multi-bed rooms in acute settings to support the development of healthcare acquired infection guideline.
- a budget impact analysis of the implementation of the stop smoking national clinical guideline.

## Health Research Board Emerging Investigator Award

HIQA is a co-applicant on the Health Research Board Emerging Investigator Award (EIA) led by Dr Barbara Clyne, HRB-CICER and RCSI, entitled *Evidence synthesis and translation of findings for national clinical guideline development: addressing the needs and preferences of guideline development groups*. This research aims to support clinical guideline development processes underlying the work conducted by HRB-CICER by developing a 'toolkit' for evidence producers and end users. This toolkit will support:

1. optimal selection of evidence synthesis methods
2. communication of the findings of evidence synthesis and
3. translation of research evidence into recommendations.

During 2020, work commenced on:

- a commentary on the experience of including preprints in rapid reviews during the COVID-19 pandemic
- developing a Delphi study on optimal selection of evidence synthesis methods
- and an analysis of Irish media coverage of rapid review results during the COVID-19 pandemic.

## Health Research Board Collaborative Doctoral Award

HIQA is a co-applicant on the Health Research Board Collaborative Doctoral Award led by Professor Susan Smith, RCSI, which funds a programme entitled *Managing complex multimorbidity in primary care: a multidisciplinary doctoral training programme*. The programme includes a collaboration with HIQA to evaluate the costs of adhering to clinical guidelines falling on patients with complex multimorbidity and their carers, an area under researched to date.

During 2020, a systematic of review of qualitative evidence was undertaken and published. Work also commenced on an analysis of out-of-pocket healthcare costs for people with multimorbidity using routine datasets.

## 4.2.5 Evidence for Policy

Our Evidence for Policy (EfP) Team was established in 2018 following a request from the National Patient Safety Office (NPSO) in the Department of Health. The EfP Team is responsible for the effective implementation of evidence synthesis programmes to deliver high-quality research to support policy development by the Department of Health.

### **Evidence review of specialist cardiac services**

The National Review of Specialist Cardiac Services is an independently chaired review of national clinical cardiac services in Ireland established by the Minister for Health. The review will recommend the optimal configuration of a national adult specialist cardiac service in Ireland, aiming to achieve optimal patient outcomes at a population level with particular emphasis on the safety, quality and sustainability of the services that patients receive. We carried out an evidence review to inform the National Review of Specialist Cardiac Services.

The three main objectives of our evidence review were to:

1. identify and describe existing models of specialist cardiac networks focused on the urgent treatment of patients presenting with a STEMI (major) heart attacks. STEMI heart attacks are caused by a blockage in the arteries supplying blood to the heart muscle. They are considered a medical emergency and are treated urgently by using either a clot-busting drug (thrombolysis) or by inserting a guide wire into the artery and opening the vessel using a balloon to allow the blood to flow to the heart muscle again. This is known as a primary percutaneous coronary intervention (PCI), and is done in a hospital that has an emergency catheterisation laboratory (cath lab).
2. identify international best practice for centres providing PCI to treat STEMI heart attacks and to examine the evidence underpinning these criteria.
3. identify evidence on the safety and effectiveness of strategies for managing STEMI heart attacks including primary PCI and thrombolysis approaches in centres without PCI-capability.

The completed evidence review was submitted to the Steering Group of the National Review of Specialist Cardiac Services in 2020.

## **The economic burden of antimicrobial resistance in the public acute care system in Ireland**

Antimicrobial resistance is a global public health concern; it is defined as the ability of a micro-organism to stop an antimicrobial from working against it. As standard antimicrobial treatments become ineffective, infections persist and spread, increasing morbidity and mortality. Rising rates of antimicrobial resistance will make it increasingly difficult and expensive to control and treat infections, and places a significant burden on society.

In 2020, we continued work on a study to estimate the economic burden of antimicrobial resistance in the public acute care system in Ireland. This costing study is being undertaken to address Strategic Objective 5 of Ireland's National Action Plan on Antimicrobial Resistance (2017-2020). Economic evidence of the current cost of antimicrobial resistance could inform investment decisions, and promote and provide a metric against which to measure the use of proposed evidence-based, cost-effective solutions to challenges faced as a result.

An expert advisory group comprising representative stakeholders is providing guidance and expert input to the project. The report will be provided as advice to the Minister for Health in 2021.



## 4.2.6 Stakeholder engagement

### National and international networks

In 2019, we signed a memorandum of understanding (MoU) between national health technology assessment (HTA) bodies in Scotland, Wales and Ireland.

The MoU established a collaborative approach to the identification and assessment of new health technologies between HIQA, the HSE, Health Technology Wales and the Scottish Health Technology Group. Collaboration has included HIQA team members acting as dedicated reviewers for assessments produced by the other member agencies. Early in the course of the COVID-19 pandemic, the agencies maintained regular contact regarding COVID-19-related work requests, in order to reduce duplication of effort, with the agencies collaborating on a number of reviews, some of which were subsequently updated and published as EUnetHTA collaborative reviews. A collaborative proposal submitted in November 2020 by HIQA, Health Technology Wales, the Scottish Health Technology Group and other international health technology agencies (including the Swedish Agency for Health Technology and the Canadian Agency for Drugs and Technologies in Health), has been accepted for a panel discussion at the Health Technology Assessment international (HTAi) conference in 2021. The topic of the panel discussion will be 'Embedding Impact Evaluation in Health Technology Assessment: Successes and Challenges'.

HIQA is a member of both HTAi and the International Network of Agencies for Health Technology Assessment (INAHTA). These international collaborations allow us to share research and collaborate on and co-produce evidence reviews on health technologies.

HIQA has been nominated by the Department of Health to represent Ireland in the European Network for Health Technology Assessment (EUnetHTA) since 2008. EUnetHTA is a collaboration of over 80 HTA organisations from all 28 EU member states, Norway and Switzerland. It aims to bring about effective and sustainable HTA collaboration that creates added value at European, national and regional levels. A series of Joint Actions have been undertaken to foster interagency cooperation, improve HTA output and avoid duplication of effort. This work has also informed the establishment of a permanent Europe-wide network of HTA agencies.

HIQA is an active participant in four of the work packages included in EUnetHTA's third Joint Action 2016-2021. HIQA's Director of HTA and Deputy Chief Executive, Dr Máirín Ryan, is an elected member of the EUnetHTA Executive Board.



During 2020, we worked with EUnetHTA on a number of projects, including as:

- co-author on the rapid HTA on surgical procedures for treatment of obesity (due for completion in 2021).
- dedicated reviewer on a rapid assessment of the 24-hour blood pressure measurement device Mobil-O-Graph® with the built-in algorithm ARCSolver® to measure arterial stiffness for the optimisation of hypertension treatment and assessment of cardiovascular disease risk.
- dedicated reviewer on a rapid collaborative review on the current role of antibody tests for novel coronavirus SARS-CoV-2 in the management of the pandemic.
- dedicated reviewer on a rapid collaborative review on the diagnostic accuracy of molecular methods that detect the presence of SARS-CoV-2 virus in people with suspected COVID-19.

We also contribute to a number of advisory groups and networks run by external stakeholders. These include the Technology Review Group of the HSE National Cancer Control Programme, the Technology Review Group of the HSE Rare Diseases Programme, the HSE HTA Expert Group, the SPHeRE Steering Group, the HSE Community Health Schemes (Medicines) Open Data Project Governance Committee and the Department of Health's Health System Performance Assessment Stakeholder Group.

## Evidence Synthesis Ireland

We collaborate on the Evidence Synthesis Ireland initiative led by Professor Declan Devane, National University of Ireland Galway (NUIG), which aims to strengthen Ireland's capabilities in evidence synthesis to promote evidence-informed health decision-making. Evidence Synthesis Ireland is funded by the HRB and the Public Health Agency, Northern Ireland. HIQA is one of four placement sites for successful applicants to undertake training in systematic review and other evidence synthesis skills. In 2020, members of the HTA Directorate presented two webinars hosted by Evidence Synthesis Ireland. The first was on how the evidence from systematic reviews is used to inform national clinical guidelines and HTAs in Ireland. The second was on conducting evidence synthesis during the COVID-19 pandemic.

The Director of HTA is a member of the International Advisory Board for Evidence Synthesis Ireland.



### European Health Parliament

In December 2020, a member of the directorate, Health Economist Paul Carty, was selected as a member of the Healthy Economies Committee of the 2021 European Health Parliament, a movement to connect and empower the next generation of European health leaders. The Healthy Economies Committee aims to develop European-level actionable evidence-based policy recommendations to promote economic recovery and ensure longer term health system resilience and economic sustainability. The policy recommendations will be published in June 2021.

*Paul Carty, our Health Economist*

## 4.3 Health and social care standards

Working in conjunction with a wide range of stakeholders, we aim to improve the quality and safety of health and social care services by setting national standards and developing supporting tools. Standards promote practice that is up to date, evidence based, effective and consistent. Standards help the people who provide health and social care services to identify strengths and highlight areas that may need improvement. National standards show people what safe, high-quality care should look like and what to expect from a service. When national standards are finalised, we also develop additional support materials to help health and social care services and staff to understand and implement them in practice.

### 4.3.1 Building capacity and capability in health and social care services

In 2018, a HIQA review into methodologies used internationally for developing national standards for health and social care services identified that jurisdictions were placing major emphasis on the development of support tools to aid understanding of and assist in the implementation of national standards. The international review has served as an important resource to inform changes in the strategic direction of HIQA's standards-setting function. It has resulted in an additional focus on supporting the implementation of national standards through the development of guidance, digital learning solutions and self-assessment tools; this is reflected in HIQA's Corporate Plan 2019–2021.

We are committed to developing support tools to assist services to build capacity among health and social care staff and to ensure there is sustained quality improvement within services. One such example is through the development of online learning modules for front-line staff. In 2020, we launched two online learning modules to support the implementation of national standards in the areas of infection prevention and control, and adult safeguarding. Both modules are hosted on the HSE learning and development online learning platform (HSE LanD) to maximise reach and ensure they are accessible to front-line staff. More information about the modules and how to access them is available on our website.

## National Standards for infection prevention and control in community services: Putting the standards into practice

The *National Standards for infection prevention and control in community services* were published in 2018. In August 2020, we launched an online learning module to support health and social care staff to implement the standards. The module is an important resource for front-line staff working in health and social care services, demonstrating how they can practically implement the standards in their day-to-day work. It contains practical examples, real-life scenarios and day-to-day practice tips for staff across a range of health and social care settings in the community, such as residential services for older people and people with a disability, day care services, GP practices, dental services and care delivered in the home.



The module covers areas such as communicating well with people using services, involving people in decisions about their care, providing care in a clean and safe environment, and prescribing antimicrobial medication in a safe manner. It aims to promote good practice in the area, while also addressing knowledge and skills gaps identified through extensive stakeholder engagement. It contains self-reflection questions to help staff think about how they are already applying the standards, identify areas they may be able to improve and how they might set about doing that.

By the end of 2020, 16,362 people had completed the module, the majority of whom are front-line staff working in community health and social care services. An online evaluation form, designed to gather feedback on the module and assess its impact, was completed by 3,781 people. Based on these evaluations, 93% of people said the course gave them a better understanding of what the national standards look like in practice, 78% intend to change their practice having completed the course and 95% would recommend the course to a colleague.

## National Standards for Adult Safeguarding: Putting the standards into practice

*National Standards for Adult Safeguarding*, jointly developed with the Mental Health Commission (MHC), were launched in December 2019. In 2020, we worked with the MHC to develop an online learning module to support people who work in health and social care services to implement the national standards in their day-to-day practice. The module, launched in November, aims to promote good practice in the area, while also addressing knowledge and skills gaps identified through extensive stakeholder engagement throughout the standards development process.



The module highlights the importance of working in a way that places people using services at the centre of everything the services do. It has been designed to build on the understanding of front-line staff using real-life scenarios, giving staff the tools necessary to ensure care is person centred. It contains self-reflection questions to help staff to think about how they are already applying the standards, identify areas they may be able to improve and how they might set about doing that.

By the end of 2020, 4,842 people had completed the module, the majority of whom are front-line staff working in health and social care services — 35% working in residential care for older people.

An online evaluation form, designed to gather feedback on the module and assess its impact, was completed by 994 people. Based on these evaluations, 98% of people said the course gave them a better understanding of what the national standards look like in practice, 79% intend to change their practice having completed the course and 87% would recommend the course to a colleague.

## **Guidance on a Human Rights-based Approach in Health and Social Care Services**

Following the publication of *Guidance on a Human Rights-based Approach in Health and Social Care Services* in 2019, we continued to develop awareness and training materials in 2020 for service providers and staff, to ensure that the rights of people using health and social care services are protected, promoted and supported in practice, and embedded in the culture of a service.

We published an academic slide-deck for those teaching health and social care students and providing training for health and social care staff. This was developed in response to a number of requests from academic institutions to deliver modules to their students in this area. In addition, we have developed four online learning modules for staff in health and social care services and a video animation for people using services, which will be launched in early 2021.

## **Implementation of health and social care standards**

To promote evidence-based practice and to inform the work of our Standards Team, a PhD student has been funded to undertake research on the 'Implementation of health and social care standards in health and social care services; identification of enablers, barriers and development of support tools'.

This research aims to support and enhance the implementation of health and social care standards by identifying and describing the enablers and the barriers to implementation. It will then develop tailored support tools to overcome the barriers to implementing standards in health and social care services.

The research will contribute towards developing an innovative implementation framework that can be applied to future standards projects and will also support the broader implementation of standards in health and social care.

During 2020, the following progress was made:

- Narrative review of definitions of health and social care standards used internationally. A preliminary version of the findings has been accepted for publication as an abstract by the National Institute of Health Sciences, Research Bulletin in spring 2021.
- Systematic review on enablers and barriers to implementation of Standards has commenced. The protocol has been published in HRB (Health Research Board) Open Research, which is an open access publishing platform for research.

## 4.3.2 National standards


### **Overarching National Standards for the Care and Support of Children using Health and Social Care Services**

In 2020, we commenced the development of Overarching National Standards for the Care and Support of Children using Health and Social Care Services. These standards are being developed jointly with the Mental Health Commission (MHC). The standards aim to drive improvement and promote best practice in order to improve the experience of all children using health and social care services. They aim to help services focus on the needs of the child first. These standards, being developed based on evidence and stakeholder input, will help health and social care services to plan for and deliver high-quality child-centred care and support.

All children have the right to receive health and social care services that are focused on their needs, and care and support that is delivered in a consistent and coordinated way by the range of services they engage with. To do this, children's needs must be assessed by these services, and the care and support they receive must be well planned, integrated, and responsive to their individual needs and circumstances. HIQA and the MHC recognise the importance of increasing the quality and safety of care and support for all children when they are using health and social care services provided by statutory agencies, as well as by voluntary and private service providers. These services include general practice, primary care services, hospitals, child protection and welfare services, children's residential centres, services for children with disabilities, and mental health services. The development of these overarching national standards is an opportunity to support improvements in the quality, consistency and continuity of all health and social care services involved in the care and support of children.

In 2020, we completed an evidence review to inform these standards. The evidence review summarises international, national and academic evidence to identify characteristics of good child-centred practices in children's health and social care services. A scoping consultation was undertaken in September 2020 to inform the development of the standards, receiving 71 responses. All feedback was assessed and will inform the development of the standards.

Throughout the development of the overarching standards for children, we will engage widely with children, their families and other key stakeholders with experience of health and social care services to ensure that the standards are fit for purpose in an Irish context, and can be implemented in practice.



**“** *A Children’s Reference Group has also been convened to inform the development of the standards. This group will run in parallel to the Advisory Group and is comprised of young people and family members with experience of using a range of health and social care services for children. The group will give insight into the issues that are important to children and families using services, so that this is reflected in the content of the standards. The first meeting of the Children’s Reference Group took place in November 2020.*

We recognise that while national standards are one component that will improve consistency for children, in order for the standards to be effective, national policy and structures to support effective inter-agency working are also required. Our in-depth stakeholder engagement process seeks to facilitate strategic discussion and direction at a senior level to influence the additional elements that need to be in place in order to drive improvements.

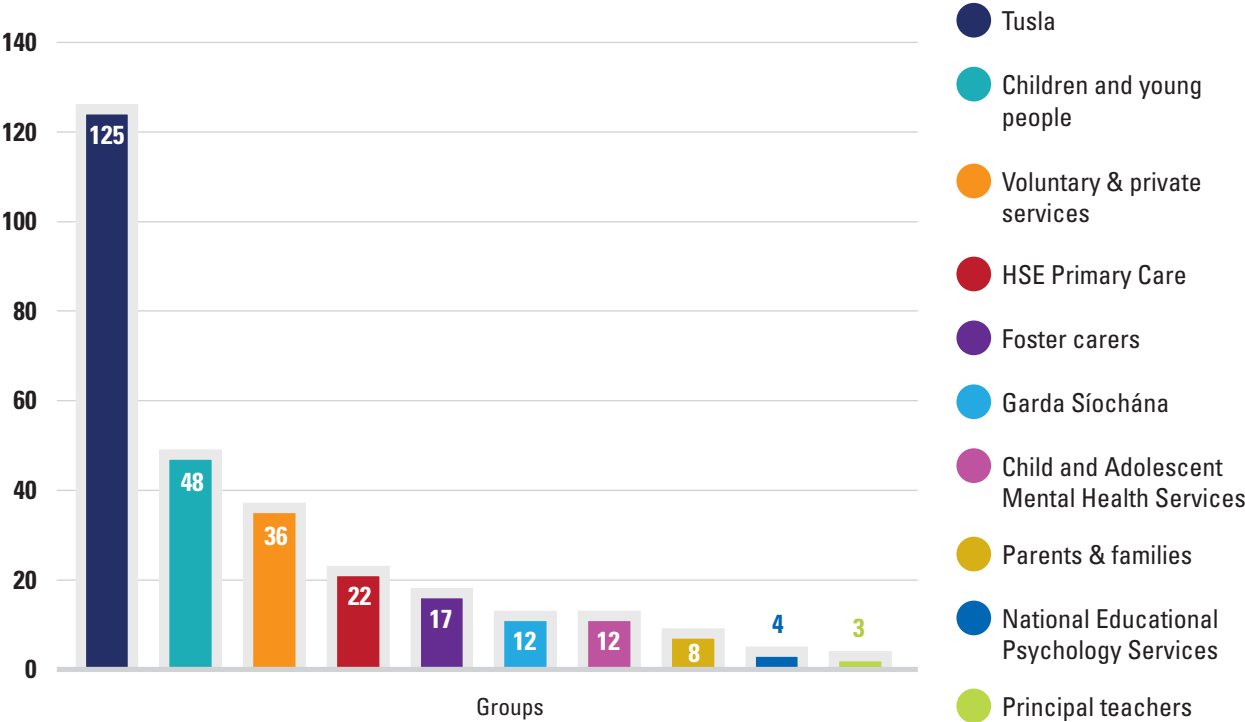
### **National Standards for Children’s Social Services**

We are also developing National Standards for Children’s Social Services. Based on recommendations from the 2018 HIQA investigation into the management of information in Tusla services, we began developing these standards to cover all children’s social services from a child’s referral to a service, until they move to another service or leave children’s social services. These standards aim to support staff working with children who are at risk or who are in the care of the State to understand how their work can support positive outcomes for children and their families in the short, medium and long term. The standards will replace existing standards for individual services, and will apply at all points of the child’s engagement with these services.

To date, an evidence review has been undertaken to inform the development of the standards and is available on HIQA’s website. A public scoping consultation has been held and we have engaged extensively with a wide range of stakeholders, including seldom-heard children, young people and families with experience of children’s social services. In 2020, we met with 287 stakeholders, including children, young people, family members, advocates, and staff members to inform the development of the standards. See Figure 23 below for a breakdown of focus group participants.



**Figure 23 – Focus group participants to inform National Standards for Children’s Social Services**



Written from the perspective of the child and setting out what a service needs to do to achieve the standards, these standards set out what safe and high-quality services should look like.

The draft standards will undergo a public consultation in 2021 before being finalised.

**Principles to underpin future national standards**

We have developed a draft set of principles to underpin all future national standards for health and social care services. These principles, once finalised, will be used as HIQA’s standards development framework, replacing the eight-theme framework which HIQA has used to develop standards since 2012. In 2020, we completed an evidence review to inform adopting a principles-based approach and to inform the development of the principles. The evidence review was published in early 2021. The draft principles will be tested in practice through the Draft National Standards for Children’s Social Services in 2021. A public consultation will be held on these draft standards and feedback will be sought on the principles underpinning them. Following this, the principles will be finalised and used for all future national standards for health and social care services.



## **Prioritisation process for the development of national standards**

In 2020, we implemented a prioritisation process for the development and updating of national standards for health and social care services.

This prioritisation process assists to identify priority areas for the development of new national standards that will best address the health and social care needs of the Irish population and which have the greatest impact in improving the outcomes of people using health and social care services. It also ensures that requests for national standards are reviewed, assessed and progressed in a transparent and consistent manner.

Proposals are assessed in key areas of impact including: potential for improved experience and outcomes for service users, evidence of effectiveness, alignment with national policy and legislation, and feasibility of implementation. The prioritisation process was published on [www.hiqa.ie](http://www.hiqa.ie) in October 2020.

A programme advisory group is in place for this process and includes key stakeholders from the Department of Health; Department of Children, Equality, Disability, Integration and Youth; Tusla; National Patient Forum; HSE; and HIQA's Regulation Directorate.

Following assessment of the proposals received in 2020, national standards for home support services were prioritised as the next set of standards to be developed. Work on this project commenced at the end of 2020 and will continue throughout 2021.

## 4.4 Health information

HIQA has two health information teams — Technical Standards and Health Information Quality — that work collaboratively, using best available evidence, to develop recommendations to support decision-making for the Irish eHealth and health information landscape. We drive improvements in the quality of data and information by developing national standards and guidance and assessing compliance with these national standards.

We work independently to gather the best available evidence to inform policy, legislation and service provision in the area of health information. The ultimate aim is to have quality data and information to support individual care, planning and management of services, policy-making and research in Ireland's health and social care systems.

Working collaboratively with key stakeholders, we gather national and international evidence on best practice. We consult with experts, stakeholders, service providers and service users. We report on the implementation of our national standards and guidance and support organisations to improve health information.

The National Care Experience Programme, a collaboration between HIQA, the Department of Health and HSE, aims to collect service users' views to drive improvements in health and social care services.

During 2020, the COVID-19 pandemic highlighted the need for a more integrated and responsive health information system in Ireland. The surveillance, testing, tracing and reporting of COVID-19 cases, not to mention vaccination, would be greatly enhanced by developments in health information policies, systems and legislation.

### 4.4.1 Technical Standards

In 2020, we:

- developed recommendations to support the implementation of a national, electronic patient summary.
- commenced the development of recommendations to progress the introduction of a national health information model.
- began assessing compliance of eHealth services within the HSE against supporting national standards.
- continued to support the rollout of SNOMED CT in conjunction with the SNOMED CT Governance and the National Release Centre.



## **Recommendations on the implementation of a national electronic patient summary**

A national electronic patient summary is a relevant set of information needed to treat a patient in unplanned care, such as emergency or out-of-hours treatment. To support the introduction of a national electronic patient summary in Ireland, we developed recommendations on the establishment of a national programme in 2020. The recommendations were compliant with the *National Standard on Information Requirements of a National Electronic Patient Summary* developed by HIQA in 2018. The recommendations were informed by international best practice and developed in conjunction with key stakeholders, including 59 responses to a public consultation held over a six-week period from August to September 2020. The 22 recommendations were submitted to the Minister for Health in early 2021.

The outputs from the project included:

- Best Practice Review of Summary Care Records (2020)
- As Is Analysis of the Irish eHealth Landscape (2020)
- Recommendations to the Minister for Health — Recommendations on the Implementation of a National, Electronic Patient Summary in Ireland
- Explanatory materials on eHealth key terms and a guide to healthcare interoperability in Ireland.

## **Recommendations on health information modelling in Ireland**

In 2020, we commenced the development of recommendations on health information modelling in Ireland. In the context of healthcare, an information model identifies the information that can be included when collecting and sharing clinical and administrative information. It allows key stakeholders, including clinicians, to identify the common categories of information that can be grouped together in a logical way — such as patient, medications, diagnosis — and which computer systems need to support. Recommendations on a national information model for health information in Ireland will support the collection, use and sharing of information across health information systems, including eHealth systems and national data collections (patient registries). A consultation on the draft recommendations will be held in 2021 before they are finalised.

## **eHealth review programme**

We have commenced a new review programme to assess compliance of eHealth services within the HSE against supporting national standards. In 2020, we started a review of the electronic referrals eHealth service with the aim to drive quality improvements by identifying areas of good practice and areas where improvements are necessary across eHealth services. Following the outbreak of COVID-19, work on the review was paused and will be recommenced in 2021. A guide to the review programme is available on our website.

## **SNOMED CT - National Terminology Standard**

In 2014, we made recommendations on the adoption of Systematized Nomenclature of Medicine (SNOMED CT) as the clinical terminology standard for Ireland. Following the adoption of SNOMED CT in 2016, the SNOMED CT National Release Centre for Ireland was established. The SNOMED CT Governance Group was also convened, which is chaired by Dr Kevin O'Carroll, HIQA's Technology and Standards Manager. In 2020, the fourth edition of SNOMED CT Ireland edition was released.

In 2020, a SNOMED CT dataset was developed for the assessment, testing, contact tracing and management of COVID-19 cases in Ireland and is being implemented in information systems used for the management of COVID-19 in community and hospital settings. The National Release Centre has also worked with the National Immunisation Office, public health and systems suppliers to ensure that SNOMED CT is incorporated into the IT systems developed to support the national COVID-19 vaccination programme. SNOMED CT will improve data quality, allow for interoperability between information systems, allow for internationally comparable data and allow for good recording and retrieval of data.





## **Patient portal to support care for older people**

To promote evidence-based practice and to inform the work of the Technical Standards Team, a PhD student has been funded to undertake research on the 'Development of personalised knowledge graphs for use in a patient portal to support caring for older persons'. The PhD student is a PhD scholar in Trinity University, Dublin.

This research aims to design and develop knowledge graphs, incorporate them in a patient portal prototype and evaluate how they can be used to support older people's healthcare needs and development of care plans. Knowledge graphs consist of data and, importantly, relationships between data. They provide structure for data and facilitate combining data from multiple sources so it can be used in applications, for example patient portals.

This research will contribute towards developing patient portals in Ireland. The prototype built and evaluated for an older person's care pathway can inform the building of similar for other care pathways.

In 2020, the following progress was made:

- Thesis proposal and methodology developed and approved by the academic supervision team.
- Systematic review on an evaluation framework to assess suitability of potential data sources commenced.

## 4.4.2 Health Information Quality

In 2020, we:

- developed recommendations on a model for the collection, use and sharing of health information in Ireland.
- worked in partnership with the Department of Health, HSE and patient representatives on the development and rollout of the first National Public Engagement Survey on Health Information.
- continued our review programme of compliance of national data collections with information management standards.

### **Development of recommendations on a model for the collection, use and sharing of health information in Ireland and the National Public Engagement Survey on Health Information**

In 2020, we continued work to develop recommendations on a model for the collection, use and sharing of health information in Ireland. In February 2020, we published an *International review of consent models for the collection, use and sharing of health information*. A key finding of this review was that public engagement and building a culture of trust in relation to the collection, use and sharing of health information is extremely important when developing a consent model. To inform and influence key decisions on these matters, it is essential to engage with the public at the earliest possible opportunity. Internationally, the successful introduction of new eHealth initiatives and digital technologies in healthcare has been informed by public engagement.

Working in partnership with the Department of Health, HSE and patient representatives, we held the first ever National Public Engagement Survey on Health Information in 2020. Preparation for the survey included reviewing public engagement activities undertaken in other jurisdictions to inform policy; developing methodology for a public consultation on the collection use and sharing of health information; and developing a national telephone survey in the form of a Computer-Assisted Telephone Interviewing tool using scenarios based on the Irish healthcare system.

A Steering Group, comprised of the partner organisations and patient representatives, was convened to provide guidance on the development of the survey. The group met four times in 2020. In addition, to inform the development of the survey, 21 interviews were carried out with healthcare professionals from across health and social care disciplines to hear their views on the barriers and facilitators in relation to the collection, use and sharing of personal health information. The survey received ethical approval from the Royal College of Physicians of Ireland's Research Ethics Committee. Following cognitive testing with patient representatives and members of the public, the survey was launched. A representative sample of 1,200 members of the population of Ireland completed the survey between October and December 2020, ensuring that the public's voice is heard in relation to how health information is collected used and shared. Findings from the survey will be published in 2021 and used to inform the recommendations on a model for the collection, use and sharing of personal health information.



*A representative sample of 1,200 members of the population of Ireland completed the survey between October and December 2020.*



## **Review of compliance with information management standards**

We continue to undertake a structured review programme to assess compliance with *Information management standards for national health and social care data collections* in Ireland. The programme aims to improve information management practices by assessing compliance with the standards in individual national data collections.

Phase 1 of the programme, which looked at national data collections within the HSE only, was completed in 2019. Phase 2, which reviews organisations with a joint governance model in place between the HSE and an external agency, commenced in 2020. The first review of Phase 2 was carried out of the National Incident Management System (NIMS) within the HSE. The joint governing organisations of the system are the HSE and the State Claims Agency, which provides the incident management platform to the HSE and uses the data collected to fulfil its legally mandated claims and risk management functions.

To inform the assessment of NIMS, a review of international evidence was carried out and teleconferences were held with subject matter experts to identify and understand best practice models for incident management within health systems in other jurisdictions. Governance meetings were held with directors and senior management team members in the HSE and the State Claims Agency. In addition, site visits and focus groups were carried out with site personnel at selected HSE and HSE-funded services. Personnel interviewed included risk managers, directors of nursing, quality and patient safety lead, clinical coordinator, clinical nurse manager, an area administrator and representatives from different disciplines within primary care services. A draft review was completed at the end of 2020 and was sent to the joint governing organisations for factual accuracy. The completed report will be published in 2021.

The importance of the review programme for national data collections was particularly highlighted in 2020 in light of the COVID-19 pandemic. Many of the recommendations in a review of the Computerised Infectious Disease Reporting (CIDR) System, published in November 2019, raised issues in relation to the surveillance and reporting of data and information which was later highlighted in relation to surveillance and reporting of COVID-19 using the CIDR system.

### 4.4.3 National Care Experience Programme

The National Care Experience Programme seeks to improve the quality of health and social care services in Ireland by asking people about their experiences of care and acting on their feedback. The National Care Experience Programme is a joint initiative by HIQA, the HSE and the Department of Health. Visit [www.yourexperience.ie](http://www.yourexperience.ie) to find out more.

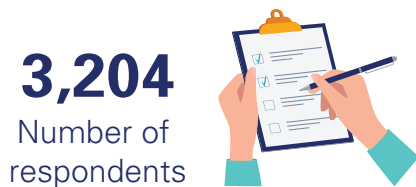
#### National Maternity Experience Survey

The National Maternity Experience Survey offered women the opportunity to share their experiences of Ireland's maternity services. The aim of the survey was to learn from the experiences of women to improve the safety and quality of the care that they and their baby receive.



The National Maternity Experience Survey was completed in 2020, with 3,204 women who gave birth in October and November 2019 sharing their maternity care experiences. This was a 50% response rate of eligible participants. The majority of women who responded to the survey had an overall positive maternity experience, with 85% of participants saying that they had a good or very good overall experience.

A webinar to launch the results of the survey was attended by 269 people. We also organised virtual townhall sessions with each of the 19 participating maternity hospitals and units and corresponding local community services and the National Home Births Service, with a total of 250 attendees across the 20 sessions.



#### Overall experience - 2020



## **National Maternity Bereavement Experience Survey**

During the development of the National Maternity Experience Survey, it was identified that a dedicated survey was required to explore the experiences of bereaved parents, to capture meaningful information on their experiences of care in a sensitive and appropriate manner.



In 2020, we commenced development of a National Maternity Bereavement Experience Survey in order to learn from parents and families about their care experience and perceptions of care following a pregnancy or perinatal loss. The survey aims to inform healthcare management of the quality and safety of care provided, drive accountability across the healthcare system and provide policy developers with definitive data to inform policy development and implementation. The survey will help to provide assurance in the care being provided and identify areas for improvement in all maternity hospitals and units in Ireland. The findings will also help inform the existing national standards for bereavement care in addition to informing regulation programmes for maternity care services.

To date, we have carried out a review of the national context on the provision of bereavement care services in maternity settings and an international review of surveys of bereaved women and parents, and engaged with international counterparts to inform the development of the survey. An extensive communications and stakeholder engagement plan is in development to support the delivery of the survey. The survey Programme Board will be convened in February 2021 and will oversee the methodology, delivery and implementation of the survey.



## Other surveys

While there is currently no existing standardised model through which to capture feedback on the lived experiences of older people in Irish nursing homes, this is a prioritised area in the National Care Experience Programme Strategy 2019-2021. A recommendation of the COVID-19 Nursing Home Expert Panel Final Report in July 2020 was to expedite the expansion of the programme to nursing home residents. A survey of experience in nursing homes will provide older people with an opportunity to share their experiences of care, and identify areas of good practice and the areas needing improvement in the provision of care. The survey aims to inform quality improvement within services, support the development of future policies and standards and to inform monitoring programmes of older people's health and social care services.

To date, we have carried out a review of the national context of older people's care in Ireland, particularly in relation to nursing homes, and have engaged with international counterparts to inform the development of the survey. An international review is currently underway, and an extensive communications and stakeholder engagement plan is in development to support the delivery of the survey. A dedicated Programme Board will be convened in 2021 and will have oversight of the methodology, delivery and implementation of the survey.

We are also progressing work on the development of a national survey of end-of-life care experience, to include people who were cared for and died in hospices, hospitals, nursing homes and in their own home. Surveying bereaved relatives is recommended as a means of evaluating the experience of care delivered as outlined in the HSE's National Clinical Care Programme for Palliative Care, Model of Care (2019). This survey aims to capture the care experience of adults who are at end of life from the perspective of bereaved relatives. It aims to establish the quality of healthcare delivered by health and social care services. The findings will build on existing good practice and inform quality improvements within services, national standards and monitoring programmes within HIQA, and national policy and legislation in the Department of Health.

Work completed to date includes carrying out an international review of national surveys of bereaved relatives, engagement with international counterparts who have undertaken similar work internationally, development of a communication and key stakeholder engagement plan, and an exploratory review of available data sources and of the feasibility of accessing data on a population-wide basis in Ireland. The Programme Board for this survey will meet in January 2021 to decide the scope, sample population, model and methodology.

### **In-depth analysis of National Inpatient Experience Surveys**

The National Care Experience Programme has worked with a team from the Insight Centre for Data Analytics, Data Science Institute, National University of Ireland Galway (NUIG) to gain a deeper understanding of the qualitative comments received in response to the 2017 and 2018 National Inpatient Experience Surveys. NUIG used a combination of traditional qualitative analysis methods, as well as data mining and machine learning techniques to identify the key activities, resources and contexts within the comments. The team then used complex statistical models to quantify how each of these factors were associated with positive and negative patient experiences. The findings of the analysis will be published in 2021. NUIG has also developed an interactive dashboard, which allows users to explore a detailed analysis and visualisation of the comments. Access to the interactive dashboard will be provided by the National Care Experience Programme to allow hospital staff to work with the data relevant to their specific hospital.

### **Survey Hub**

In 2020, the National Care Experience Programme launched a Survey Hub to provide expertise and skills and to support greater engagement with national and international stakeholders. The Survey Hub offers a suite of elearning modules and other resources for anyone aiming to capture the experiences of the people who use health and social care services, and provides advice on how to develop and implement a survey, interpret the findings, and make improvements based on the results.

Through five elearning modules, video clips and tutorials, audio files and research projects, the Survey Hub is a resource for those wanting to develop their own surveys.



## 4.5 Operations, Communications and Stakeholder Engagement and Information Division

### 4.5.1 COVID-19 response

In February 2020, we established a COVID-19 Response Committee to prepare and plan for the potential impacts of COVID-19. A robust business continuity plan was designed and implemented to facilitate HIQA staff to safely fulfil their duties remotely. As such, the vast majority of HIQA staff have been working remotely since 13 March 2020. Employees were surveyed to ensure that their temporary home workspace was suitable for work. Advice, guidance, equipment and furniture were issued to staff. To date HIQA's model of remote working has proven to be extremely effective.

Remote working technology, including the VPN (virtual private network) system capacity and softphone (making calls over the Internet), were implemented at short notice to allow our normal work to continue remotely.

Furthermore, our Information Division established a COVID-19 Business Intelligence dashboard to enable HIQA to closely monitor COVID-19 developments in the health and social care sector. It also implemented an update on the online Provider Portal to facilitate additional reporting from providers of designated centres.

The unprecedented challenges faced by the organisation in 2020 required organisational and individual flexibility and agility. The emerging challenges, and the requirements to support the national efforts in relation to the pandemic resulted in adjustments to the workforce to support these needs. Staff were redeployed inside and outside of the organisation. The skills and expertise of HIQA staff were required across the public sector, and a number of employees were redeployed.

From April to July 2020, two members of the Health Information – Quality Team were redeployed to the HPSC south region in the HSE to assist with COVID-19 epidemiology and surveillance. One member of the Standards Team was redeployed to COVID-19 projects from March to August 2020 and worked with the NPHE sub-group on vulnerable groups to provide evidence synthesis and develop up-to-date, evidence-based and accessible guidance on COVID-19. Following this, they were redeployed to the HPSC to develop public health guidance.

## Contact tracing

In March, as part of the national response to COVID-19, HIQA assisted the HSE with contact tracing. This involved training approximately 80 staff to take calls such as contacting positive cases and giving them advice, collating details of close contacts and phoning the close contacts to give advice. An operational team was set up within the Regulation Directorate to ensure that the service was trained, updated, managed and coordinated as part of the wider national contact tracing resource.

At the start of June, the HSE evaluated the resources required to support contact tracing nationally and the HIQA support was stepped down.



*Our staff conducting contact tracing training in March 2020.*

### 4.5.2 Information Division

Our Information Division supported the business in 2020, including through providing ongoing technical and ICT support to staff, enabling and maintaining remote working, and preparing for a new suite of technologies (such as a Business Process Management system, a modern customer relationship management [CRM] system).

To assist staff while remote working, we also implemented an electronic signature solution for the signing of notices of proposed decision and notices of decision for designated centres.

We also created a multi-year Digital and Data Transformation Strategy and technology roadmap to transform how the organisation operates into the future. The strategy aims to support and enable HIQA to work into the future through enabling digital technology advances, and improved data analysis and reporting tools.

### 4.5.3 Communications and stakeholder engagement

Our Communications and Stakeholder Engagement Team supported HIQA's work throughout the year. The team is responsible for communicating and engaging with a wide range of stakeholders including the Government and opposition, media, health and social care services, service users and employees. The team manages the organisation's publications, media relations, website, social media accounts, graphic design, internal communications and complaints.

In 2020, this work included publishing:

- 76 documents on our work in evidence synthesis, health information, regulation, and standards and guidance development
- 1,132 inspection reports
- 45 press releases
- 67 publication statements
- 6 issues of external newsletter, *HIQA News*
- 12 issues of staff e-zine.

Visitors to our website homepage, [www.hiqa.ie](http://www.hiqa.ie), increased from over 133,000 in 2019 to over 152,000 in 2020. HIQA's social media accounts also grew throughout the year with the establishment of an Instagram account, and a steady increase in followers across all other platforms.

We received and responded to 24 parliamentary questions throughout the year. We also submitted five reports on our work to various Oireachtas committees.

During the year, HIQA made six submissions to public consultations on:

- the Child Care Act 1991 run by the Department of Children, Equality, Disability, Integration and Youth
- the Draft Implementation Framework for Children and Young people's Participation in Decision-making run by the Department of Children, Equality, Disability, Integration and Youth
- the Dental Council's Draft Requirements for Undergraduate Dental Education
- the HSE's new Corporate Plan
- the Law Reform Commission's Regulatory Framework for Adult Safeguarding
- and the Mapping Opportunities for Patient and Public Involvement run by the Irish Platform for Patient Organisations, Science & Industry (IPPOSI).



## 4.5.4 Operations

### Financial management

Throughout 2020, HIQA continued to manage its financial resources in line with good practice and all relevant governance requirements. The use of planning and ongoing financial management enabled HIQA to use its resources efficiently and effectively.

HIQA's internal financial controls were audited during the year by our internal audit provider. No material concerns were identified. Improvements were made to the financial management system that processes financial transactions and provides management information to support decision-making.

HIQA's annual accounts for 2020 were submitted to the Comptroller and Auditor General in accordance with the timescales set out in the Health Act 2007.

### Health and safety

HIQA is committed to protecting the safety, health and welfare of all employees and visitors in its offices. Health and safety is a standing item on the Board's agenda at each meeting. We continue to invest resources in a health and safety programme which enables colleagues to actively participate in the management of their own health and safety. Staff safety representatives sit on the Health and Safety Committee which meets quarterly. Health and safety training is delivered to help staff acquire the skills, knowledge and attitude to make them competent in the safety and health aspects of their work and instil a positive health and safety culture.

In 2020, HIQA took all required precautions to protect the small numbers of staff who had occasion to attend its offices through full implementation of the Government's Return to Work Safely Protocol. Staff who had to carry out inspection activities were provided with training, guidance and personal protective equipment in line with public health guidance.

There was one reportable incident to the Health and Safety Authority (HSA) during the year.

## **Human resources**

Our Human Resources Team continues to support the organisation in the development of its internal capabilities.

The team rolled out a Learning and Development Strategy and competency framework in 2020. The framework was integrated into recruitment and selection and learning and development activities. Managers were supported to proficiency map the competencies for each role.

Recruiting managers received a training programme on competency-based interviewing. A programme on having effective development conversations was developed for both managers and staff.

In 2020, HIQA was successful in the National Standards Authority of Ireland assessment for Excellence Through People (ETP) accreditation and was awarded Gold Standard certification.

Recruitment and selection practices were reengineered to operate in the changed environment. Activities that were previously face-to-face moved online. New and more innovative platforms for advertising were utilised. Employee induction programmes were also adjusted to support new starters.

## **Corporate social responsibility**

During the year, employee wellbeing was a key focus as we endeavoured to support staff through the challenges they faced at work and at home. A comprehensive wellbeing programme was put in place with a focus on supporting the particular health and wellbeing requirements of the workforce during the pandemic. It included activities to address employees' physical, emotional and mental wellbeing. Staff were also encouraged to avail of the employee assistance programme for any additional support required.

In 2020, HIQA staff established a Diversity and Inclusion Working Group to encourage and support diversity and inclusion in the organisation. During the year, this staff-led initiative ran a number of online interactive sessions for staff on human rights, LGBTQI+ community in Ireland and Alzheimer's disease. The group also began developing recommendations on improving diversity and inclusion and will continue this work into 2021.

The organisation also continued to reduce its environmental impact, and exceeded the targets set by Government to reduce our energy consumption by 33% by 2020. See Appendix 4 for more information on energy consumption.

# 5

# Annual financial statements

Year Ended 31 December 2020

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## HIQA Board membership

<b>Name</b>	<b>Role</b>
Pat O Mahony	Chairperson
James Kiely	Board Member
Caroline Spillane	Board Member
Paula Kilbane	Board Member
Michael Rigby	Board Member
Tony McNamara	Board Member
Lynsey Perdisatt	Board Member
Bernadette Costello	Board Member

## General information

**Address** Unit 1301,  
City Gate,  
Mahon,  
Cork  
T12 Y2XT

**Bankers** Ulster Bank  
95 Main Street  
Midleton  
Co Cork  
P25 RW67

**Auditors** Comptroller and Auditor General  
3A Mayor Street Upper  
Dublin 1  
D01 PF72

**Solicitors** Beauchamps  
Riverside Two  
Sir John Rogerson's Quay  
Dublin 2  
D02 KV6

## Statement on Internal Control

### 1. Scope of responsibility

On behalf of the Health Information and Quality Authority (HIQA) I acknowledge the Board's responsibility for ensuring that an effective system of internal control is maintained and operated. This responsibility takes account of the requirements of the Code of Practice for the Governance of State Bodies 2016, and adherence to HIQA's own Code of Governance.

### 2. Purpose of the system of internal control

The system of internal control is designed to manage risk to a tolerable level rather than to eliminate it. The system can therefore only provide reasonable, and not absolute, assurance that assets are safeguarded, transactions authorised and properly recorded and that material errors or irregularities are either prevented or detected in a timely way.

The system of internal control, which accords with guidance issued by the Department of Public Expenditure and Reform, has been in place in HIQA for the year ended 31 December 2020 and up to the date of approval of the financial statements.

### 3. Capacity to Handle Risk

HIQA has an Audit, Risk and Governance Committee comprising three Board members and one external member with financial expertise. The Committee met six times during 2020.

HIQA has outsourced its internal audit function to an independent professional firm who conduct a programme of work agreed with the Audit, Risk and Governance Committee and the Board.

A risk management policy and procedure has been approved by the Board, which sets out HIQA's risk appetite, the risk management processes in place, and the roles and responsibilities of staff in relation to risk. This policy has been issued to all staff who are expected to work within HIQA's risk management policies, to alert management on emerging risks and control weaknesses, and assume responsibility for risks and controls within their own area of work.

### 4. Risk and control framework

HIQA has implemented a risk management system which identifies and reports key risks and the management actions being taken to address and, to the extent possible, to mitigate those risks.

## Statement on Internal Control *(continued)*

A risk register is in place which identifies the key risks facing HIQA. Risks have been identified, evaluated and graded according to their significance, and are regularly reviewed as appropriate by various levels within the organisation including management, the Audit, Risk and Governance Committee, other committees of the Board and the Board. These assessments are used to plan and allocate resources to ensure risks are managed to an acceptable level.

The risk register details the controls and actions needed to mitigate risks and responsibility for operation of controls assigned to specific staff. I confirm that a control environment containing the following elements, is in place:

- procedures for all key business processes have been documented,
- financial responsibilities have been assigned at management level with corresponding accountability,
- there is an appropriate budgeting system with an annual budget which is kept under review by senior management,
- there are systems aimed at ensuring the security of the information and communication technology systems,
- there are systems in place to safeguard assets.

In March 2020, in line with public health advice and government policy, most of HIQA's staff started to work from home and this continued for the rest of the year. HIQA already had systems and controls in place that facilitated dispersed and remote working. The security of remote working capability has been assessed independently and improvements have been implemented. Potential security and control threats are monitored and addressed on an ongoing basis. HIQA has been able to continue its operations without disruption and with minimal changes to its risk and control processes.

### 5. Ongoing monitoring and review

Formal procedures have been established for monitoring control processes and control deficiencies are communicated to those responsible for taking corrective action, to management and to the Board, where relevant, in a timely way. I confirm that the following ongoing monitoring systems are in place:

- key risks and related controls have been identified and processes have been put in place to monitor the operation of those key controls and report any identified deficiencies
- reporting arrangements have been established at all levels where responsibility for financial management has been assigned, and
- there are regular reviews by senior management of periodic and annual performance and financial reports which indicate performance against budgets and forecasts.

## Statement on Internal Control *(continued)*

### 6. Procurement

I confirm that HIQA has procedures in place to ensure compliance with current procurement rules and guidelines and during 2020, HIQA complied with those procedures.

### 7. Review of effectiveness

I confirm that HIQA has procedures to monitor the effectiveness of its risk management and control procedures. HIQA's monitoring and review of the effectiveness of the system of internal control is informed by the work of the internal and external auditors, the Audit, Risk and Governance Committee and senior management within HIQA who are responsible for the development and maintenance of the internal control framework.

I confirm that the Board conducted an annual review of the effectiveness of the internal controls for 2020.

### 8. Internal control issues

No weakness in internal control were identified in relation to 2020 that require disclosure in the financial statements.

On behalf of the Board,



**Pat O'Mahony**  
Chairperson

Date: 21 April 2021

# Governance Statement and Board Members' Report

## 1. Governance

The Board of the Health Information and Quality Authority (HIQA) was established under the Health Act 2007. The functions of the Board are set out in Section 8 of the Act. The Board is accountable to the Minister for Health and is responsible for ensuring good governance. The Board performs this task by setting strategic objectives and targets and taking strategic decisions on all key business issues. The regular day-to-day management, control and direction of HIQA are the responsibility of the Chief Executive and the senior management team.

The Chief Executive and the senior management team follow the broad strategic direction set by the Board, and ensure that all Board members have a clear understanding of the key activities and decisions related to the entity, and of any significant risks as they arise. The Chief Executive acts as a direct liaison between the Board and management of HIQA.

## 2. Board responsibilities

The work and responsibilities of the Board are set out in HIQA's Code of Governance which also contains the matters specifically reserved for Board decision. Standing items considered by the Board include:

- declaration of interests,
- reports from committees,
- financial reports and management accounts,
- performance reports, and
- reserved matters as arise.

Section 35 of the Health Act requires the Board of HIQA to keep, in such form as may be approved by the Minister for Health with consent of the Minister for Public Expenditure and Reform, all proper and usual accounts of money received and expended by it.

In preparing these financial statements, the Board of HIQA is required to:

- select suitable accounting policies and apply them consistently,
- make judgments and estimates that are reasonable and prudent,
- prepare the financial statements on a going concern basis unless it is inappropriate to presume that it will continue in operation, and
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the financial statements.



## Governance Statement and Board Members' Report

*(continued)*

The Board is responsible for keeping adequate accounting records which disclose, with reasonable accuracy at any time, its financial position and enables it to ensure that the financial statements comply with Section 35 of the Health Act 2007. The Board is responsible for approving the annual plan and budget. An evaluation of HIQA's performance against the annual plan and budget is carried out annually and on an ongoing basis.

The Board is also responsible for safeguarding its assets and taking reasonable steps for the prevention and detection of fraud and other irregularities. The Board considers that the financial statements of HIQA give a true and fair view of the financial performance and the financial position of HIQA at 31 December 2020.

### 3. Board structure

The Board consists of a Chairperson and eleven ordinary members, all of whom are appointed by the Minister for Health. Currently, the Board has four vacancies.

Name	Role	Tenure commenced	Tenure expires
<b>Pat O'Mahony</b>	Chairperson of the Board	03/10/2018	02/10/2023
<b>Paula Kilbane</b>	Board Member	29/07/2015 30/09/2020	28/07/2020 29/09/2025
<b>James Kiely</b>	Board Member	26/02/2018	25/02/2023
<b>Caroline Spillane</b>	Board Member	26/02/2018	25/02/2023
<b>Lynsey Perdisatt</b>	Board Member	02/09/2019	01/09/2024
<b>Tony McNamara</b>	Board Member	02/09/2019	01/09/2024
<b>Michael Rigby</b>	Board Member	02/09/2019	01/09/2024
<b>Bernadette Costello</b>	Board Member	28/02/2020	27/02/2025

Former Board members

<b>Molly Buckley</b>	Board Member	29/07/2015	28/07/2020
<b>Stephen O'Flaherty</b>	Board Member	29/07/2015	28/07/2020
<b>Martin Sisk</b>	Board Member	29/07/2015	28/07/2020

## Governance Statement and Board Members' Report

*(continued)*

Enda Connolly, who was appointed on 26 February 2018, resigned from the Board on 23 October 2020.

During 2020, HIQA was assessed by the National Standards Authority Ireland (NSAI) against its standard for corporate governance. The objective of this review is to assess an organisation's corporate governance frameworks and specifically the level of compliance against the relevant codes of practice, including the Code of Practice for the Governance of State Bodies 2016 and emerging practices of good governance. The assessment found that HIQA is demonstrating full compliance with prevailing best-practice standards of corporate governance.

An external evaluation of Board performance was carried out in 2019/2020.

### 4. Committees of the Board

The Board has established four committees, as follows:

- a) Audit Risk and Governance Committee:** The role of the Audit Risk and Governance Committee is to support the Board in relation to its responsibilities for issues of risk, control and governance and associated assurance. The Committee is independent from the financial management of the organisation. In particular the Committee ensures that the internal control systems including audit activities are monitored actively and independently. The Committee reports to the Board after each meeting, and formally in writing annually. An external independent person is also a member of the Committee.
- b) Resource Oversight Committee:** This committee monitors the resource requirements of HIQA to ensure that they are aligned with HIQA's corporate strategy including oversight of resource related risks. In addition, it oversees managerial performance.
- c) Regulation Committee:** This committee oversees the effectiveness, governance, compliance and controls around the delivery of HIQA's regulatory functions.
- d) Standards, Information, Research and Technology Committee:** This committee oversees the governance arrangements, including compliance and controls, for the functions of standards development, health information and health technology assessment functions.

## Governance Statement and Board Members' Report

(continued)

### 5. Schedule of attendance, fees and expenses for Board members and external committee members

A schedule of attendance at Board and Committee meetings in 2020 is set out below, including the fees and vouched expenses paid to each member:

#### (a) Current Board Members

	Statutory Board meeting	Extra Board meetings	Audit, Risk and Governance Committee	Regulation Committee	Standards, Information Research and Technology Committee	Resource Oversight Committee	Fees	Vouched expenses
Number of meetings	6	5	6	4	3	5		-
Pat O'Mahony	6 of 6	5 of 5	N/A	N/A	N/A	5 of 5	€11,970	-
James Kiely <sup>1 2</sup>	6 of 6	4 of 5	5 of 5	2 of 2	3 of 3	4 of 5	€7,695	-
Caroline Spillane <sup>3</sup>	5 of 6	4 of 5	5 of 6	1 of 2	N/A	N/A	€7,695	€50
Paula Kilbane <sup>4 5 6</sup>	4 of 4	5 of 5	N/A	2 of 2	1 of 1	N/A	€6,358	-
Michael Rigby	5 of 6	5 of 5	N/A	4 of 4	3 of 3	N/A	€7,695	€42
Tony McNamara	6 of 6	5 of 5	N/A	4 of 4	3 of 3	N/A	€7,695	-
Lynsey Perdisatt <sup>7</sup>	5 of 6	5 of 5	2 of 2	N/A	N/A	5 of 5	-	-
Bernadette Costello <sup>8 9 10</sup>	5 of 5	3 of 4	6 of 6	N/A	N/A	1 of 1	€6,442	€500
<b>Total</b>							<b>€55,550</b>	<b>€592</b>

1 Ceased as a member of ARGC from 20/09/2020

2 Appointed to regulation committee 20/09/2020

3 Ceased to be a member of Regulation Committee from 20/9/2020

4 Board membership expired 28/07/2020

5 Reappointed to Board 30/09/2020

6 Appointed to SIRT committee 10/11/2020

7 Appointed to ARGC 20/09/2020

8 Joined Board on 29/02/2020

9 Joined ROC 20/09/2020

10 Joined ARGC 29/02/2020

# Governance Statement and Board Members' Report

(continued)

## (b) Former Board Members

	Statutory Board meeting	Extra Board meetings	Audit, Risk and Governance Committee	Regulation Committee	Standards, Information Research and Technology Committee	Resource Oversight Committee	Fees	Vouched expenses
Number of meetings	6	5	6	4	3	5		
Martin Sisk*	3 of 4	3 of 4	N/A	N/A	1 of 1	2 of 4	€4,405	-
Molly Buckley*	4 of 4	4 of 4	N/A	2 of 2	N/A	N/A	€4,405	-
Stephen O'Flaherty*	3 of 4	4 of 4	4 of 4	N/A	N/A	4 of 4	€4,405	-
Enda Connolly**	0	0	0	N/A	0	N/A	€6,413	-
<b>Total</b>							<b>€19,628</b>	<b>-</b>

\*tenure expired July 2020

\*\*resigned 23 October 2020

## (c) External Audit, Risk and Governance Committee Members

Bernadette Costello was an external member of the Audit, Risk and Governance Committee until her appointment to HIQA Board on 29 February 2020. She attended two of two Audit, Risk and Governance Committee meetings as external committee member and was paid €570 for fees and €318.18 for expenses in this capacity.

Donal Curtin was appointed as an external committee member to HIQA's Audit, Risk and Governance Committee on 29/02/2020 and has attended four of the five Audit, Risk and Governance Committee meetings during 2020. No fees or expenses were paid to him in 2020.

Fees were paid to Board members at the approved standard rates for the periods involved.

Fees are not paid to Board members employed in the public service, under the 'One Salary One Person Principle' directive, issued by the Department of Public Expenditure and Reform. As a result, one of HIQA's Board members, during the year were not in receipt of fees (Lynsey Perdisatt).

In addition to vouched expenses paid directly to Board members, a further €340 was paid by HIQA for hotel accommodation. In these instances no subsistence was claimed by the Board member.

# Governance Statement and Board Members' Report

(continued)

## 6. Disclosures required by Code of Practice for the Governance of State Bodies

The Board is responsible for ensuring that HIQA has complied with the requirements of the Code of Practice for the Governance of State Bodies 2016. The following disclosures are required by the code.

### 6.1 Employee Short Term Benefits

Employee short-term benefits in excess of €60,000 are set out in note 6 of the Annual Financial Statements.

### 6.2 Consultancy Costs

Consultancy costs include costs of external expert analysis and advice to management which contributes to decision making or policy direction. It excludes outsourced 'business as usual' functions

	<b>2020</b>	<b>2019</b>
	<b>€</b>	<b>€</b>
<b>Consultancy</b>		
Legal advice	73,265	49,977
Human resources	3,354	33,302
Governance and strategy	54,029	44,814
Digital and data transformation	648,179	240,357
<b>Total consultancy</b>	<b>778,827</b>	<b>368,450</b>
Consultancy costs charged to capital account*	587,954	79,750
Consultancy costs charged to the Income and Expenditure and Retained Revenue Reserves**	190,873	288,700
<b>Total</b>	<b>778,827</b>	<b>368,450</b>

\*Included in Statement of Capital Income and Expenditure

\*\*Included in Professional Services in the Income and Expenditure Statement

## Governance Statement and Board Members' Report

(continued)

### 6.3 Legal Costs and Settlements

	2020	2019
	€	€
Legal fees – legal proceedings (Note 1)	174,160	114,491
Legal Settlement (Note 2)	(40,000)	-
<b>Total</b>	<b>134,160</b>	<b>114,491</b>

**Note 1** The table provides details of expenditure in the reporting period in relation to a range of legal proceedings. It includes three disputes with public sector organisations that were either heard or are pending a hearing in court. This does not include expenditure incurred in relation to general legal advice received by HIQA which is disclosed in consultancy services above.

**Note 2** Included in legal proceedings is a receipt of €40,000 in settlement of HIQA legal costs associated with a Judicial Review, for which party to party costs were awarded to HIQA against the applicant in 2019.

### 6.4 Travel and Subsistence Expenditure

Travel and Subsistence Expenditure is categorised as per note 8 of the Annual Financial Statements.

### 6.5 Hospitality

The Income and Expenditure and Retained Revenue Reserves Statement includes the following hospitality expenditure:

	2020	2019
	€	€
Board and Staff Hospitality	1,231	1,144
<b>Total</b>	<b>1,231</b>	<b>1,144</b>

# Governance Statement and Board Members' Report

*(continued)*


## 7. Statement of compliance

The Board has adopted the Code of Practice for the Governance of State Bodies 2016 and put procedures in place to ensure compliance with the Code. HIQA was in full compliance with the Code of Practice for the Governance of State Bodies for 2020.

On behalf of the Board,

Signed:   
**Pat O'Mahony**  
Chairperson

Date: 21 April 2021

Signed:   
**Caroline Spillane**  
Board Member

Date: 21 April 2021

# Comptroller and Auditor General Report

## Report for presentation to the Houses of the Oireachtas Health Information and Quality Authority

### Qualified opinion on financial statements

I have audited the financial statements of the Health Information and Quality Authority for the year ended 31 December 2020 as required under the provisions of section 35 of the Health Act 2007. The financial statements have been prepared in accordance with Financial Reporting Standard (FRS) 102 — *The Financial Reporting Standard applicable in the UK and the Republic of Ireland and comprise*

- the statement of income and expenditure and retained revenue reserves
- the statement of capital income and expenditure
- the statement of financial position
- the statement of cash flows and
- the related notes, including a summary of significant accounting policies.

In my opinion, except for the non-compliance with the requirements of FRS 102 in relation to retirement benefit entitlements referred to below, the financial statements give a true and fair view of the assets, liabilities and financial position of the Health Information and Quality Authority at 31 December 2020 and of its income and expenditure for 2020 in accordance with FRS 102.

### Basis for qualified opinion on financial statements

In compliance with the directions of the Minister for Health, the Health Information and Quality Authority accounts for the costs of retirement benefit entitlements only as they become payable. This does not comply with FRS 102 which requires that the financial statements recognise the full cost of retirement benefit entitlements earned in the period and the accrued liability at the reporting date. The effect of the non-compliance on the Health Information and Quality Authority's financial statements for 2020 has not been quantified.

I conducted my audit of the financial statements in accordance with the International Standards on Auditing (ISAs) as promulgated by the International Organisation of Supreme Audit Institutions. My responsibilities under those standards are described in the appendix to this report. I am independent of the Health Information and Quality Authority and have fulfilled my other ethical responsibilities in accordance with the standards.

I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.



# Comptroller and Auditor General Report

*(continued)*

## **Report on information other than the financial statements, and on other matters**

The Health Information and Quality Authority has presented certain other information together with the financial statements. This comprises the annual report, the statement on internal control and the governance statement and board members' report. My responsibilities to report in relation to such information, and on certain other matters upon which I report by exception, are described in the appendix to this report.

I have nothing to report in that regard.



**John Crean**  
**For and on behalf of the**  
**Comptroller and Auditor General**

**28 April 2021**

# Comptroller and Auditor General Report

*(continued)*

## **Responsibilities of Board members**

As detailed in the governance statement and Board members' report the Board members are responsible for

- the preparation of financial statements in the form prescribed under section 35 of Health Act 2007
- ensuring that the financial statements give a true and fair view in accordance with FRS 102
- ensuring the regularity of transactions
- assessing whether the use of the going concern basis of accounting is appropriate, and
- such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

## **Responsibilities of the Comptroller and Auditor General**

I am required under section 35 of the Health Act 2007 to audit the financial statements of the Health Information and Quality Authority and to report thereon to the Houses of the Oireachtas.

My objective in carrying out the audit is to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement due to fraud or error. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with the ISAs will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

As part of an audit in accordance with the ISAs, I exercise professional judgment and maintain professional scepticism throughout the audit. In doing so,

- I identify and assess the risks of material misstatement of the financial statements whether due to fraud or error; design and perform audit procedures responsive to those risks; and obtain audit evidence that is sufficient and appropriate to provide a basis for my opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.

## Comptroller and Auditor General Report

*(continued)*

- I obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the internal controls.
- I evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures.
- I conclude on the appropriateness of the use of the going concern basis of accounting and, based on the audit evidence obtained, on whether a material uncertainty exists related to events or conditions that may cast significant doubt on the Health Information and Quality Authority's ability to continue as a going concern. If I conclude that a material uncertainty exists, I am required to draw attention in my report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify my opinion. My conclusions are based on the audit evidence obtained up to the date of my report. However, future events or conditions may cause the Health Information and Quality Authority to cease to continue as a going concern.
- I evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation.

I communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that I identify during my audit.

### **Information other than the financial statements**

My opinion on the financial statements does not cover the other information presented with those statements, and I do not express any form of assurance conclusion thereon.

In connection with my audit of the financial statements, I am required under the ISAs to read the other information presented and, in doing so, consider whether the other information is materially inconsistent with the financial statements or with knowledge obtained during the audit, or if it otherwise appears to be materially misstated. If, based on the work I have performed, I conclude that there is a material misstatement of this other information, I am required to report that fact.



## Comptroller and Auditor General Report

*(continued)*

### Reporting on other matters

My audit is conducted by reference to the special considerations which attach to State bodies in relation to their management and operation. I report if I identify material matters relating to the manner in which public business has been conducted.

I seek to obtain evidence about the regularity of financial transactions in the course of audit. I report if I identify any material instance where public money has not been applied for the purposes intended or where transactions did not conform to the authorities governing them.

I also report by exception if, in my opinion,

- I have not received all the information and explanations I required for my audit, or
- the accounting records were not sufficient to permit the financial statements to be readily and properly audited, or
- the financial statements are not in agreement with the accounting records.

## Statement of Income and Expenditure and Retained Revenue Reserves

For the year ended 31 December 2020

	Notes	2020 €	2019 €
<b>Income</b>			
Department of Health (Vote 38, E1)		17,269,000	15,700,000
Annual and registration fees	2	7,250,687	7,202,745
Other income	3	1,541,888	1,450,150
		<b>26,061,575</b>	<b>24,352,895</b>
<b>Expenditure</b>			
Staff costs	4	19,888,956	18,394,752
Travel and subsistence	8	422,235	864,461
Professional fees	9	663,235	823,182
Publication expenses		41,153	99,580
Support costs	10	2,365,672	2,390,704
Establishment expenses	11	2,269,857	1,965,164
		<b>25,651,108</b>	<b>24,537,843</b>
Surplus/(Deficit) for the year		410,467	(184,948)
Surplus as at 1 January		1,131,753	1,316,701
Surplus at 31 December		<b>1,542,220</b>	<b>1,131,753</b>

The Statement of Income and Expenditure and Retained Revenue Reserves includes all gains and losses recognised in the year with the exception of depreciation and amortisation which are included in the Statement of Capital Income and Expenditure.

The Statement of Cash Flows and Notes 1 to 19 form part of these financial statements.

On behalf of the Health Information and Quality Authority,

Signed: 

**Pat O'Mahony**  
Chairperson

Date: 21 April 2021

Signed: 

**Phelim Quinn**  
Chief Executive

Date: 21 April 2021

## Statement of Capital Income and Expenditure

For the year ended 31 December 2020

		2020	2019
	Notes	€	€
<b>Income</b>			
Department of Health (Vote 38, L)	15	2,052,108	1,490,595
Amortisation of Capital Fund Account	15	1,240,474	1,006,855
		<b>3,292,582</b>	<b>2,497,450</b>
<b>Expenditure</b>			
Fixtures and fittings	12	15,343	15,128
Computer equipment	12	1,448,811	1,395,717
Non capital expenditure	15	587,954	79,750
Depreciation	12	1,240,474	1,006,855
		<b>3,292,582</b>	<b>2,497,450</b>
<b>Surplus/(Deficit) for the Year</b>		-	-
Opening (deficit)/surplus		-	-
<b>Surplus/(Deficit) for Year</b>		-	-

The Statement of Income and Expenditure and Retained Revenue Reserves includes all gains and losses recognised in the year with the exception of depreciation and amortisation which are included in the Statement of Capital Income and Expenditure.

The Statement of Cash Flows and Notes 1 to 19 form part of these financial statements.

On behalf of the Health Information and Quality Authority,

Signed: 

**Pat O'Mahony**  
Chairperson

Date: 21 April 2021

Signed: 

**Phelim Quinn**  
Chief Executive

Date: 21 April 2021

## Statement of Financial Position

As at 31 December 2020

		2020	2019
	Notes	€	€
<b>Fixed Assets</b>			
Tangible Assets	12	2,791,480	2,567,845
<b>Current Assets</b>			
Receivables	13	1,221,454	1,405,944
Cash and cash equivalents		2,073,259	1,215,308
		<u>3,294,713</u>	<u>2,621,252</u>
<b>Less Current Liabilities</b>			
Payables falling due within one year	14	(1,752,493)	(1,489,499)
		<u>1,542,220</u>	<u>1,131,753</u>
<b>Net Current Assets</b>			
		<u>4,333,700</u>	<u>3,699,598</u>
<b>Total Assets less Current Liabilities</b>			
		<u>4,333,700</u>	<u>3,699,598</u>
<b>Capital and Reserves</b>			
Revenue Reserves		1,542,220	1,131,753
Capital Account	15	2,791,480	2,567,845
		<u>4,333,700</u>	<u>3,699,598</u>

The Statement of Cash Flows and Notes 1 to 19 form part of these financial statements.

On behalf of the Health Information and Quality Authority,

Signed: 

**Pat O'Mahony**  
Chairperson

Date: 21 April 2021

Signed: 

**Phelim Quinn**  
Chief Executive

Date: 21 April 2021

## Statement of Cash Flows

For the year ended 31 December 2020

### Reconciliation of Operating Surplus to Net Funds Inflow from Operating Activities

	2020	2019
	€	€
Operating Surplus/(Deficit)	410,467	(184,948)
Decrease/(Increase) in receivables	184,490	(36,833)
Increase /(Decrease) in payables and accruals	262,994	(103,765)
Interest received	(124)	(99)
<b>Net Cash Flow from Operating Activities</b>	<b>857,827</b>	<b>(325,645)</b>
<b>Cash Flows from Investing Activities</b>		
Purchase of fixed assets	1,464,154	1,410,845
Non capital expenditure	587,954	79,750
Capital grants received	(2,052,108)	(1,490,595)
<b>Net Cash Flows from Investing Activities</b>	<b>-</b>	<b>-</b>
<b>Cash Flows from Financing Activities</b>		
Interest received	124	99
<b>Net Cash Flows from Financing Activities</b>	<b>124</b>	<b>99</b>
<b>Net Increase/(Decrease) in Cash and Cash Equivalents</b>	<b>857,951</b>	<b>(325,546)</b>
Cash and cash equivalents at 1 January	1,215,308	1,540,854
<b>Cash and Cash Equivalents at 31 December</b>	<b>2,073,259</b>	<b>1,215,308</b>

On behalf of the Health Information and Quality Authority,

Signed: 

**Pat O'Mahony**  
Chairperson

Date: 21 April 2021

Signed: 

**Phelim Quinn**  
Chief Executive

Date: 21 April 2021



# Notes to the Financial Statements

## For the year ended 31 December 2020

### 1. Accounting Policies

#### 1. (a) General Information

The basis of accounting and significant accounting policies adopted are set out below. They have all been applied consistently throughout the year and for the preceding year.

#### 1. (b) Statement of Compliance

The financial statements of HIQA for the year ended 31 December 2020 have been prepared in accordance with FRS102 (the financial reporting standard applicable in the UK and Ireland), as modified by the directions of the Minister for Health in relation to superannuation. In compliance with the directions of the Minister for Health, HIQA accounts for the costs of superannuation entitlements only as they become payable (see (l) and (m)). This basis of accounting does not comply with FRS102, which requires such costs to be recognised in the year in which entitlement is earned.

#### 1. (c) Basis of Preparation

The financial statements are prepared under the accruals method of accounting and under the historical cost convention in the form approved by the Minister for Health with the concurrence of the Minister for Public Expenditure and Reform, in accordance with Section 35 of the Health Act 2007.

The following accounting policies have been applied consistently in dealing with items which are considered material in relation to HIQA's financial statements.

#### 1. (d) Income

(i) Oireachtas grants

The amount brought to account in the Statement of Income and Expenditure and Retained Revenue Reserves represents the actual grants received in the accounting grants in respect of approved capital expenditure are accounted for in the Capital Income and Expenditure account on an accrual basis.

(ii) Annual fee income

Annual fees from providers of Designated Centres for Older Persons are recognised three times every year in accordance with Statutory Instrument 245 of 2009, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2009 and Statutory Instrument 493 of 2013, Health Act 2007 (Registration of Designated Centres for Older People) (Amendment) Regulations 2013.



## Notes to the Financial Statements

### For the year ended 31 December 2020

Annual fees from providers of Designated Centres for Persons with Disabilities are recognised three times every year in accordance with Statutory Instrument 366 of 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulation 2013.

(iii) Application to register or vary fees

Applications to register or vary fees are recognised on receipt of the relevant fee, in accordance with Statutory Instrument 245 of 2009, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2009 and Statutory Instrument 366 of 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulation 2013.

(iv) Other grants

Other grants, such as EU project funded grants are recognised on an accrual basis.

#### **1. (e) Employee - short-term benefits**

Short term benefits such as holiday pay are recognised as an expense in the year and benefits that are accrued at year-end are included in the payables figure in the Statement of Financial Position.

#### **1. (f) Receivables**

Receivables are recognised at fair value, less a provision for doubtful debts. The provision for doubtful debts is a specific provision and is established when there is objective evidence HIQA will not be able to collect all amounts owed to it. All movements in the provision for doubtful debts are recognised in the Statement of Income and Expenditure and Retained Revenue Reserves.

Annual fee debt is only written off on the basis of management assessment of the probability of non-collection and the cost of collection versus the debt outstanding. All amounts for debt written off are recognised in the Statement of Income and Expenditure and Retained Revenue Reserves.

# Notes to the Financial Statements

## For the year ended 31 December 2020

### 1. (g) Operating lease

Rental expenditure under operating leases is recognised in the Statement of Income and Expenditure and Retained Revenue Reserves over the life of the lease. Expenditure is recognised on a straight line basis over the lease period.

### 1. (h) Capital funding

HIQA's fixed assets are funded from a combination of capital grants and allocations from current revenue. Funding sourced from grants is transferred to a capital account which is amortised in line with the depreciation of the related assets. Capital grants in respect of approved expenditure are accounted for in the Capital Income and Expenditure Statement on an accrual basis. Expenditure funded from capital funding that does not result in the creation of an asset is expensed to the Capital Income and Expenditure Statement on an accruals basis.

### 1. (i) Property, computer software, plant and equipment and depreciation

Property, computer software, plant and equipment are stated at cost less accumulated depreciation, adjusted for any provision for impairment. Depreciation is provided on all property, computer software and equipment, plant and equipment at rates estimated to write off the cost less estimated residual value of each asset on a straight line basis over their estimated useful lives, as follows:

- Leasehold interest Life of the lease
- Furniture and fittings 20%
- Computer software and equipment 33.33%
- Cloud based computer software and equipment are written off over the life of the contract

Asset acquisitions, regardless of the source of funds, are capitalised with the exception of assets funded from revenue (non-capital) grants with a value below the following threshold:

- Equipment or furniture and fittings - Less than €3,809
- Computer software or ICT equipment - Less than €1,270



## Notes to the Financial Statements

### For the year ended 31 December 2020

Residual value represents the estimated amount which would currently be obtained from disposal of an asset, after deducting the estimated costs of disposal, if the asset were already of an age and in the condition expected at the end of its useful life. If there is objective evidence of impairment of the value of an asset, an impairment loss is recognised in the Statement of Capital Income and Expenditure and Retained Revenue Reserves.

#### **1. (j) Intangible Assets**

Intangible assets comprise software acquired by HIQA. The external costs of software licences and development are capitalised where it can be separately identified as software for use by HIQA and where it is expected to convey business benefits for a number of future years. Research costs are written off as incurred.

#### **1. (k) Superannuation**

In accordance with Section 27 of the Health Act 2007, HIQA has established a superannuation scheme which has been approved by the Department of Health.

The scheme is a defined benefit superannuation scheme for employees. No provision has been made in respect of benefits payable. Contributions from employees who are members of the scheme are credited to the Statement of Income and Expenditure and Retained Revenue Reserves when received. Pension payments under the scheme are charged to the Statement of Income and Expenditure and Retained Revenue Reserves when paid. By direction of the Minister for Health, no provision has been made in respect of benefits payable in future years.

#### **1. (l) Single public service pension scheme**

All new entrants into the public sector with effect from 1 January 2013 are members of the single public service pension scheme, where all employee pension deductions are paid to the Department of Public Expenditure and Reform. Pension payments under the scheme are charged to the Statement of Income and Expenditure and Retained Revenue Reserves when paid. By direction of the Minister for Health, no provision has been made in respect of benefits payable in future years.

# Notes to the Financial Statements

## For the year ended 31 December 2020

### 1. (m) Critical accounting judgments and estimates

The preparation of the financial statements requires management to make judgments, estimates and assumptions that affect the amounts reported for assets and liabilities as at the statement of financial position date and the amounts reported for revenues and expenses during the year. However, the nature of estimation means that actual outcomes could differ from these estimates. The following judgment has had the most significant effect on amounts recognised in the financial statements:

#### **Depreciation and residual values**

HIQA has reviewed the asset lives and associated residual values of all fixed assets, and in particular the useful economic life and residual values of fixtures and fittings, and have concluded that assets lives and residual values are appropriate.

## Notes to the Financial Statements

### For the year ended 31 December 2020

#### 2. Annual and Registration Fee Income

	2020	2019
	€	€
Annual fees	6,798,237	6,871,145
Registration fees	452,450	331,600
	<b>7,250,687</b>	<b>7,202,745</b>

#### 3. Other Income

	2020	2019
	€	€
Superannuation contributions	459,039	460,821
EU and other grants	38,546	39,625
Mental Health Commission	3,764	20,933
Irish Human Rights and Equality Commission	-	16,000
National Screening Advisory Committee	237,123	-
European Centre for Disease Prevention and Control	21,914	29,883
Health Research Board grants	451,318	532,729
National Care Experience Program	330,000	350,000
Interest received	124	99
Miscellaneous income	60	60
<b>Total</b>	<b>1,541,888</b>	<b>1,450,150</b>

#### 4. Staff Costs

	2020	2019
	€	€
Wages and salaries	16,108,962	14,777,057
Pensions	850,689	723,279
Agency staff	1,225,227	1,368,745
Board members' fees	75,178	73,022
Employers' pay related social insurance	1,628,900	1,452,649
<b>Total</b>	<b>19,888,956</b>	<b>18,394,752</b>

Additional superannuation contributions of €509,387 (2019, €585,672) were deducted from staff salaries and remitted to the Department of Health.

## Notes to the Financial Statements

### For the year ended 31 December 2020

#### 5. Remuneration

##### 5. (a) Aggregate Employee Benefits

	<b>2020</b>	<b>2019</b>
	€	€
Employee short-term benefits	16,108,962	14,777,057
Outstanding annual leave entitlement	220,889	126,742
Employer's contribution to social welfare	1,628,900	1,452,649
	<b>17,958,751</b>	<b>16,356,448</b>

The total number of staff employed, whole time equivalents, at year end was 264 (2019, 252)

##### 5. (b) Short-term Benefits

	<b>2020</b>	<b>2019</b>
	€	€
Basic pay	16,108,962	14,477,057
	<b>16,108,962</b>	<b>14,477,057</b>

##### 5. (c) Key Management Personnel

Management personnel consist of the Chief Executive, the Director of Health Technology Assessment and Deputy Chief Executive, the Director of Regulation, the Director of Health Information and Standards, and the Acting Chief Operations Officer. The total value of employee benefits for key management personnel is set out below:

	<b>2020</b>	<b>2019</b>
	€	€
Chief Executive Officer	160,524	157,031
Other Key Management Personnel	550,372	492,849
	<b>710,896</b>	<b>649,880</b>

## Notes to the Financial Statements

### For the year ended 31 December 2020

This does not include the value of retirement benefits earned in the period. The Chief Executive and the other key management personnel are members of HIQA's pension scheme and their entitlements in that regard do not extend beyond the terms of the model public service pension scheme.

HIQA's key management personnel were reimbursed €7,683 (2019, €38,185) for travel, subsistence and other expenses incurred while carrying out their duties.

Details of fees earned and expenses reimbursed to members of the Board are set out in the Governance Statement and Board members' Report.

#### 6. Employee Short-Term Benefits

Employees' short-term benefits in excess of €60,000 are categorised into the following bands:

Employee benefits	2020 Number	2019 Number
€60,001 - €70,000	86	65
€70,001 - €80,000	35	28
€80,001 - €90,000	13	14
€90,001 - €100,000	9	8
€100,001 - €110,000	5	2
€110,001 - €120,000	0	1
€120,001 - €130,000	0	0
€130,001 - €140,000	0	2
€140,001 - €150,000	2	0
€150,001 - €160,000	2	1

Total employer pension contributions paid during the year was nil (2019, nil). For the purposes of this disclosure, short-term employee benefits in relation to services rendered during the reporting period include salary, overtime allowances and other payments made on behalf of the employee, but exclude employer's PRSI.



## Notes to the Financial Statements

### For the year ended 31 December 2020

#### 7. Average Headcount

	<b>2020</b>	<b>2019</b>
Regulation	170	163
Health Technology Assessment	14	14
Health Information and Standards	26	23
Support staff	51	48
	<u><b>261</b></u>	<u><b>248</b></u>

As at 31 December, HIQA employed 264 whole time equivalent staff (2019, 252).

#### 8. Travel and Subsistence

	<b>2020</b>	<b>2019</b>
	<b>€</b>	<b>€</b>
<b>Domestic</b>		
Board	932	5,797
Employees	413,218	809,728
<b>International</b>		
Employees	4,999	38,254
External professional services*	3,086	10,682
	<u><b>422,235</b></u>	<u><b>864,461</b></u>

Board travel and subsistence includes €592 paid directly to Board members (2019, €3,600). The balance of €340 (2019, €2,197) relates to expenditure paid by HIQA on behalf of the Board members in relation to hotel accommodation. Where hotel accommodation was provided by HIQA, no subsistence was claimed by the Board member.

\*This cost relates to travel and subsistence costs which were incurred by HIQA as part of the contractual cost associated with the receipt of certain professional services.

## Notes to the Financial Statements

### For the year ended 31 December 2020

#### 9. Professional Fees

	2020	2019
	€	€
<b>Consultancy</b>		
Legal advice	207,425	164,468
ICT professional services and consultancy	229,978	357,449
Standards development and health technology assessments	7,949	27,522
Organisational development	77,469	119,950
Human resources information system	3,030	(5,982)
Estate Services	30,589	-
Staff survey	-	17,158
Facilitation and coaching services	24,509	21,632
External accreditations	3,176	3,229
Pension support services	8,926	7,893
Procurement services	5,218	8,358
Website review	10,164	13,776
Board risk and governance workshop	(4,365)	7,457
Human Resources consultancy	3,354	33,302
Governance and strategy consultancy	54,029	44,814
Other	1,784	2,156
<b>Total professional services</b>	<b>663,235</b>	<b>823,182</b>

## Notes to the Financial Statements

### For the year ended 31 December 2020

#### 10. Support costs

	2020	2019
	€	€
Recruitment	144,075	157,654
Staff training and development	353,972	251,743
Advisory membership and subscriptions	131,506	185,911
Telephone	144,080	132,886
IT support and supplies	1,402,367	1,475,054
Internal audit	78,551	56,725
External audit	17,000	13,000
Postage and stationery	75,882	96,731
Media monitoring	7,890	11,002
Couriers	7,663	7,618
Prompt payment interest and charges	1,652	1,197
Bank charges	1,034	1,183
<b>Total</b>	<b>2,365,672</b>	<b>2,390,704</b>

## Notes to the Financial Statements

### For the year ended 31 December 2020

#### 11. Establishment Expenses

	2020	2019
	€	€
Rent	1,342,149	1,215,415
Building service charge	202,031	187,311
Insurance	(1,147)	6,165
Repairs and maintenance	278,502	60,036
Meeting room hire	1,386	17,594
Stakeholder events and catering	15,306	45,734
Light and heat	129,729	129,409
Cleaning and refuse	155,522	127,230
Security	129,852	160,490
Record retention and storage	2,920	3,306
Health and safety	13,607	12,474
<b>Total</b>	<b>2,269,857</b>	<b>1,965,164</b>

## Notes to the Financial Statements

### For the year ended 31 December 2020

#### 12. Fixed assets

	Leasehold interest	Fixtures and fittings	Computer equipment	Total
€	€	€	€	€
<b>Cost or valuation</b>				
Balance at 1 January 2020	2,067,364	729,817	5,104,756	7,901,937
Additions	-	15,343	1,448,811	1,464,154
Disposals	-	-	(72,552)	(72,552)
Cost or valuation at 31 December 2020	<u>2,067,364</u>	<u>745,160</u>	<u>6,481,015</u>	<u>9,293,539</u>
<b>Accumulated depreciation</b>				
Balance at 1 January 2020	1,109,816	657,017	3,567,259	5,334,092
Depreciation charge for the period	109,126	22,734	1,108,614	1,240,474
Accumulated depreciation on disposal	-	-	(72,507)	(72,507)
Accumulated depreciation at 31 December 2020	<u>1,218,942</u>	<u>679,751</u>	<u>4,603,366</u>	<u>6,502,059</u>
<b>Net book value at 31 December 2020</b>	<u><b>848,422</b></u>	<u><b>65,409</b></u>	<u><b>1,877,649</b></u>	<u><b>2,791,480</b></u>
<b>Net book value at 31 December 2019</b>	<u><b>957,548</b></u>	<u><b>72,800</b></u>	<u><b>1,537,497</b></u>	<u><b>2,567,845</b></u>

## Notes to the Financial Statements

### For the year ended 31 December 2020

#### 13. Receivables

	<b>2020</b>	<b>2019</b>
	€	€
Annual fee receivables	244	305
Prepayments	581,631	727,376
Department of Health – Capital Grants receivable	205,077	387,905
Project Debtors	390,944	233,753
Payroll Receivables	19,524	25,140
Other Receivables	24,034	31,465
	<b>1,221,454</b>	<b>1,405,944</b>

#### 14. Payables (amounts falling due within one year)

	<b>2020</b>	<b>2019</b>
	€	€
Payables	65,251	59,006
Prepaid income	48,949	62,786
Prepaid project income	231,261	3,764
Trade accruals	642,785	763,432
Payroll deductions	543,358	473,769
Holiday pay accrual	220,889	126,742
	<b>1,752,493</b>	<b>1,489,499</b>

## Notes to the Financial Statements

### For the year ended 31 December 2020

#### 15. Capital Account

	2020	2019
	€	€
Opening balance at 1 January	2,567,845	2,163,855
<b>Movement for period</b>		
Expenditure from capital and ICT programme grant	2,052,108	1,490,595
Non capital expenditure (Note 1)	(587,954)	(79,750)
Disposals	(72,552)	(113,767)
Amount amortised in line with depreciation for the period	(1,240,474)	(1,006,855)
Accumulated depreciation on disposals	72,507	113,767
<b>Balance at 31 December</b>	<b>2,791,480</b>	<b>2,567,845</b>

**Note 1** Non capital expenditure relates to expenditure on professional fees, which have not met the FRS 102 definition of a fixed asset.

#### 16. Capital Commitments

	2020	2019
	€	€
Contracted for	100,262	349,170
	<b>100,262</b>	<b>349,170</b>

## Notes to the financial statements

### For the year ended 31 December 2020

#### 17. Leasehold Commitments

HIQA is currently occupying three leased premises (Cork, Dublin and Galway). In all cases the lease agreement is between the landlord and the Office of Public Works.

The lease in respect of City Gate, Mahon, Cork was entered into in 2008 for a term of 20 years and one month. The annual rent payable is €388,941. As a result of agreements entered into as part of the decentralisation programme, this rent is paid by The Office of Public Works and is not recouped from HIQA.

The lease in relation to Smithfield in Dublin was entered into 2008 for a 20-year term. The annual rent payable is €1,172,774.

The lease in relation to Headford Road in Galway was entered into on 1 February 2016 for a 10-year term. The annual rent payable is €19,350.

#### 18. Board Members' Interests

The Authority has procedures for dealing with conflicts of interest, in accordance with guidelines issued by the Department of Public Expenditure and Reform.

#### 19. Approval of Financial Statements

These financial statements were approved by the Board on 21 April 2021.



# Appendices

## Appendix 1: Annual protected disclosures report

Under section 22 of the Protected Disclosures Act 2014 each public body is required to publish an annual report outlining the number of protected disclosures received in the previous year and the action taken (if any). This report must not result in the identification of persons making a protected disclosure.

The Minister for Public Expenditure and Reform has, under Section 7(2) of the Protected Disclosures Act 2014, prescribed the Chief Executive of HIQA as an appropriate recipient of disclosures of relevant wrongdoings relating to all matters relating to the standards of safety and care of persons receiving health and social care services in the public and voluntary healthcare sectors and social care services in the case of the private healthcare sector, as provided for by the Health Act 2007. Any such disclosures made can only be dealt with in a way that is consistent with, and appropriate to the role, statutory rights and duties of HIQA.

During 2020, a full review of the protected disclosure process was undertaken and a more streamlined process was put in place for the receipt of protected disclosures. This included a review of the Protected Disclosure policy and procedure, the development of guidance documents and refresher training for staff. In addition, we updated the information on our website setting out for persons or workers, other than HIQA employees, how to make a protected disclosure to us, what information needs to be submitted and what HIQA does with a disclosure. We also developed *Guidance for Making a Protected Disclosure to HIQA* and this is also available on HIQA's website here.

This report covers the period of 1 January 2020 to 31 December 2020.

In 2020, 17 disclosures received were assessed under the Protected Disclosure Act 2014. This information was logged and risk-assessed and in each case used to inform the most appropriate intervention by HIQA as a regulator of health and social care services and in compliance with its duties under the Protected Disclosures Act 2014.

No disclosures were made by a member of staff during 2020.



## Appendix 2: **Service Charter**

HIQA has developed a Service Charter for the purpose of providing information to people engaging with our services on the level of service they can expect from us. The Charter sets out our commitment to engaging with our stakeholders in line with the principles of quality customer service for customers and clients of the public service. We also developed a 2019-2021 action plan, which includes specific and measurable targets aimed at developing and improving aspects of our interactions with those who engage with us for whatever purpose.

We have published progress on implementing our Service Charter action plan in 2020 on [www.hiqa.ie](http://www.hiqa.ie).

### Appendix 3: Freedom of Information report

HIQA received a total of 107 Freedom of Information (FOI) requests in 2020, carrying over two from 2019. These figures represent a 41% increase in FOI requests to HIQA over the previous year. Further details on these requests are provided in the tables below.

In the interests of transparency, HIQA began publishing non-personal FOI requests, including the decisions issued and records that were released under FOI in 2020. These can be viewed on HIQA’s website.

The public information on FOI on HIQA’s website was also updated.

2020 FOI Requests	
Brought forward from 2019	2
Received 2020	107
<b>Total Requests Handled</b>	<b>109</b>
Brought forward into 2021	5
<b>Closed in 2020</b>	<b>104</b>

2020 Closure Breakdown	
Granted	12
Part Granted	52
Refused	10
Transferred	3
Withdrawn	7
Dealt with outside FOI	20

## Appendix 4: Energy consumption

Over the past 12 months, HIQA has continued to work towards and has exceeded the targets set by Government to reduce our energy consumption by 33% by 2020. Vastly reduced numbers of staff in HIQA's offices due to the COVID-19 pandemic restrictions will have contributed to this. In conjunction with the Sustainable Energy Authority of Ireland (SEAI) and the Office of Public Works (OPW), HIQA has achieved a total energy saving of 37.7% on our baseline year 2010. This achievement reflects HIQA's commitment to reduce its carbon footprint and help to develop a more sustainable work environment for both colleagues and the community at large. We will continue to work with the SEAI and the OPW towards the new targets set by Government which is a 50% energy reduction and 30% carbon reduction by 2030.

HIQA has undertaken a number of projects to realise the goals to date and continue to invest in energy saving initiatives. While the figures above indicate the overall goals, we are awaiting clarification on the baseline data to be used for the revised targets. If they retain the current base line data then we are well on our way to meeting this objective. If, however, the base line figures are adjusted, HIQA will re-evaluate its plans for achieving these goals.

### HIQA Smithfield

Description	Electricity	Gas	Total
Benchmark Year (2010)	513,114	608,769	1,121,883
Previous 12 months	308,461	360,064	668,525
<b>% Difference</b>	<b>-39.9%</b>	<b>-40.9%</b>	<b>-40.4%</b>

### HIQA Cork

Description	Electricity	Gas	Total
Benchmark Year (2010)	215,128	0	215,128
Previous 12 months	167,868	0	167,868
<b>% Difference</b>	<b>-22.0%</b>	<b>0.0%</b>	<b>-22.0%</b>

**Cork + Smithfield total benchmark year vs total last 12 months to December 2020, No HDDCs<sup>19</sup> used**

<b>Description</b>	<b>Electricity</b>	<b>Gas</b>	<b>Total</b>
Benchmark Year	728,242	608,769	1,337,011
Previous 12 months	476,329	360,064	836,393
<b>% Difference</b>	<b>-34.6%</b>	<b>-40.9%</b>	<b>-37.4%</b>

19 Heating Degree Days Corrected.



## Appendix 5: **Complaints management**

HIQA welcomes comments, suggestions and complaints about its performance and conduct in the discharge of its statutory duties and responsibilities. This feedback may come from service providers, patients, carers, relatives, private and voluntary organisations, statutory agencies and the general public. HIQA welcomes all feedback and regards complaints as opportunities to review practice, procedures and identify areas for improvement. We also wish to resolve complaints in an effective and timely manner, and use an early resolution approach to complaints wherever possible.

During 2020, five complaints were received by HIQA, all of which were dealt with in accordance with our policy.

## Appendix 6: Irish Human Rights and Equality Commission Act 2014

The Irish Human Rights and Equality Commission Act 2014 Section 42 places an obligation on all public bodies to uphold the public sector duty to protect human rights, promote equality and eliminate discrimination. HIQA is compliant with its public sector duty under the Act; however, the organisation is ambitious in this regard and wishes to develop its human rights approach further.

In 2020, HIQA carried out a review of how it promotes equality and protects human rights in all its activities. It found that staff were strongly committed to human rights in all areas of the organisation; the protection of rights and promotion of equality was supported by HIQA's vision and implicit in its policies and procedures.

HIQA's human resources function supports equality of opportunity in its recruitment processes, the development of a competency framework and in its learning and development opportunities. It has fair procedures in place and promotes equality in its grievance policy and dignity at work processes as well as its equality policy.

HIQA will identify the specific 'human rights and equality issues it believes to be relevant to the functions and purpose of the body' during 2021. Once done, HIQA will develop a human rights and equality framework and apply this to all processes it develops as well as its corporate plan.

The protection of rights and promotion of equality is a central tenet of HIQA's regulatory functions. In 2021, we will amplify the voice of adults and children who use regulated and monitored services and provide more information on human rights. HIQA is advocating to the Department of Health for amendments to the Health Act 2007 and its regulations which will strengthen its approach in this regard.

HIQA's development of standards, recommendations, guidance and health technology assessments has always been informed by human rights and equality issues. These two functions will also be making improvements to their processes to further emphasise human rights factors.

HIQA will report on these plans in its Annual Report for 2021.

## Appendix 7: Conferences and lectures

During 2020, HIQA employees presented the organisation's work at a number of conferences and webinars and delivered lectures to students. These events and lectures included:

- 2020 SPHeRE Annual Conference, Royal College of Surgeons in Ireland.
- Lecture on Implementation Science to the MSc group in Advanced Leadership in the RCSI School of Nursing and Midwifery in February 2020.
- Implementation Science workshops for the Ireland and Northern Ireland Network on Implementation Science in August 2020.
- Data and eHealth Master Class for Nursing Managers Series of Webinars on 25 July 2020.
- International HealthInf (Health Informatics) Conference in February 2020.
- Lectures were delivered for the UCC Masters in Public Health and MSc Digital Health and to those completing the SPHeRE PhD programme.
- All Ireland Maternity and Midwifery Event.
- Evidence Synthesis Ireland webinar: Evidence to Policy: the HIQA experience of evidence synthesis during the COVID-19 pandemic.
- Evidence Synthesis Ireland webinar: Using systematic reviews in National Clinical Guidelines and Health Technology Assessment in Ireland.
- Guidelines International Network webinar: HTA & Guidelines: What can we learn from each other.
- Fire Safety in Healthcare Services Conference.




*HIQA's team at the SPHeRE Conference on 25 February 2020. From left to right: Linda Drummond, Orla Bruton, James Larkin, Michelle Williams, Dr Kieran Walsh, Sarah Fitzgerald, Judy Gannon, Dr Máirín Ryan, Paul Dunbar, Dr Eamon O Murchu and Liam Marshall.*



## Appendix 8: Academic publications

- Cardwell, K., Jordan, K., Byrne, P., Smith, S. M., Harrington, P., Ryan, M., & O'Neill, M. The effectiveness of non-contact thermal screening as a means of identifying cases of Covid-19: a rapid review of the evidence. *Reviews in Medical Virology*. 2020. e2192.
- Carty PG, McCarthy M, O'Neill SM, Harrington P, O'Neill M, Teljeur C, Smith SM, Ryan M. Laboratory-based dried blood spot testing for hepatitis C: A protocol for systematic review and meta-analysis of diagnostic accuracy. *HRB Open Research*. October 2020. 3(78):78
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  - Teljeur C, Ryan M. Supporting the public health response to COVID-19 in Ireland: the role of HIQA. *Irish Geography*. 2020; 53(2): 145-149
  - Walsh KA, Jordan K, Clyne B, Rohde D, Drummond L, Byrne P, Ahern S, Carty PG, O'Brien KK, O'Murchu E, O'Neill M, Smith SM, Ryan M, Harrington P. SARS-CoV-2 detection, viral load and infectivity over the course of an infection. *J Infect*. September 2020. 81(3):357-371. doi: 10.1016/j.jinf.2020.06.067
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