Board Paper 18.2 16

Item 16/40.2

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

To improve health and provide excellent care

Title:	**Strengthening Board Governance and Business Standards**

Author:	**Mrs Grace Lewis-Parry, Board Secretary** **Mrs Liz Jones, Head of Corporate Affairs** **Ms Dawn Sharp, Assistant Board Secretary**

Responsible Director:	**Mrs Grace Lewis-Parry, Board Secretary**

Summary of Key Issues:	The Health Board has an ongoing programme of work to strengthen its governance arrangements and associated business standards. Mrs Ann Lloyd, Independent Adviser is supporting this work as part of Special Measures. Proposals for improving the effectiveness of the Board and its Committees are presented for the Board's approval. It is proposed that the new committee structure and updated business standards are implemented with effect from 1.3.16.

Action Required By Board:	**To:**	
	Note	
	Endorse	
	Ratify	
	Approve	√

Corporate Objective	Good governance
Finance	No significant impact
Quality Impact Assessment	No significant impact
Health and Care Standards	Governance, leadership & accountability
Equalities, Diversity & Human Rights	No significant impact
Risk & Assurance	The aim of this paper is to address the issues identified as part of Special Measures relating to Board Governance and effectiveness.

Strengthening Board Governance and Business Standards

The principles of good governance, Standing Orders, recommendations from external reports and more recently, the placing of the Health Board in Special Measures, drive the Board's ongoing programme of work to strengthen its governance arrangements and associated business standards. To this end, a range of proposals is presented herewith for the Board's approval.

1. Effectiveness of the Board and its Committees

1.1 Role of the Board

The unique role of the Board is to

- Formulate and implement strategy
- Ensure that the organisation is held to account robustly for the delivery of the Board's strategy and across a range of performance, quality and safety measures
- Shape a positive culture within the Board and its staff
- Maintain high standards of corporate governance, operating effectively with openness, transparency and candour
- Ensure effective financial stewardship
- Seek assurance on the quality and safety of services and the management of risks that threaten the successful achievement of the organisation's strategic objectives

1.2 Function

The Board functions as a corporate decision making body. Executive Directors and Independent Members are full and equal members sharing corporate responsibility for all decisions of the Board. The Board is supported by the Board Secretary who acts as principal advisor on all aspects of governance within the Health Board.

1.3 Pattern of meetings and development sessions

The Board will meet monthly in public and consider core agenda items relating to Special Measures, Financial Performance, and the Integrated Quality & Performance Report (IQPR). On a bi-monthly basis the agenda will be expanded to include other key business matters. On those months where the Board agenda is focussed on the core items, the afternoon will be utilised for additional Board briefings as necessary. In addition, there will be monthly Board Development days as part of a planned programme. This will include workshops, training, briefings, statutory & mandatory training. In 2016/17 the development programme will include a range of key priorities:- the quality, safety and sustainability of services, health inequalities, patient & public engagement and involvement, staff engagement, organisational culture, longer term strategic plans, testing systems of assurance, financial strategies, improving cost effectiveness, workforce, estates and best practice.

The Board and its committees will engage in post-meeting reflection in the interests of continuous improvement. The main day for Board and committee meetings will routinely be Thursdays.

1.4 Openness and accountability

In order to improve its effectiveness and meet its aspirations for openness and accountability, the Board will be transparent about the decisions it makes and the way in which it operates. Board and committee meetings will be held in public (with the exception of Audit Committee). The Board's website will be updated and will make it clearer to members of the public that they are welcome to attend meetings and listen to the discussion. The Board is developing a wider public engagement strategy which will make explicit how the public can contribute and provide feedback to the Board on its activities.

1.5 Strategic Direction

The Board has worked collectively to define its core purpose, vision and strategic goals as follows:

Our Purpose

- To improve health and provide excellent care

Our Vision

- We will improve the health of the population, with a particular focus upon the most vulnerable in our society.
- We will do this by developing an integrated health service, which provides excellent care delivered in partnership with the public and other statutory and third sector organisations.
- We will develop our workforce so that it has the right skills and operates in a research-rich, learning culture.

Our Strategic Goals

- Improve health and wellbeing for all and reduce health inequalities
- Work in partnership to design and deliver more care closer to home
- Improve the safety and outcomes of care to match the NHS' best
- Respect individuals and maintain dignity in care
- Listen to and learn from the experiences of individuals
- Support, train and develop our staff to excel
- Use resources wisely, transforming services through innovation and research

Our Values

- Put patients first
- Work together
- Value and respect each other
- Learn and innovate
- Communicate openly and honestly

These have been published and adopted by the Board in October 2015 and work is continuing to embed them in day to day practice to promote awareness and ownership. For example, personal appraisal and development review (PADR) documentation is currently being revised to incorporate the Health Board's strategic

goals. In addition, the coversheet for all Board and Committee papers has been revised to include the strategic goals, ensuring the alignment of the paper with the Health Board's priorities.

1.6 Conduct of Business – Standards of Behaviour in Public Life

All Board Members have a responsibility to abide by the Nolan principles of public life and in addition, Executive Directors must adhere to the NHS Code of Conduct (Disciplinary Rules and Standards of Behaviour). The Board has been working to produce a refreshed clear statement on the standards expected of Members. The statement, incorporating behaviours and meeting etiquette, is presented at Appendix 1. As part of the expected standards, Board Members are required to declare any interests at the beginning of Board meeting and complete a return annually. Board Members are also required to register any gifts and hospitality received. This register is available for public inspection at any time through the Office of the Board Secretary.

1.7 Business standards

1.7.1 Formal minutes are taken at every Board and committee meeting, using a set template. A summary action log is scrutinised at every meeting to ensure actions are followed up and completed satisfactorily. In 2016, the way in which Board and committee business is managed will be modernised through the introduction of a paperless electronic system. Following a formal tender process the contract to provide this has been awarded to Capgemini Nederland BV for their 'iBabs' system. For the Board to operate effectively it is crucial that it is presented with high quality professional reports on which it can make informed decisions.

1.7.2 Processes are in place for agenda setting, quality assurance and the sign-off of papers, with clear deadlines for distribution and reporting. A suite of Board business standards documentation has been developed, specifying expected administrative arrangements and responsibilities. These are all available on the Health Board's intranet and include:

- Annual cycle of business at Appendix 2
- Meetings calendar 2016
- Agenda setting, Executive and Chair sign off and submission process with associated timescales
- Revised Board/Committee paper coversheet at Appendix 3
- Guidelines for writing Board and committee papers (with the Board/Committee Chair having final sign off)
- Guidelines for writing minutes and action log template
- Standardised agenda and minutes templates
- Templates for Committee and Advisory Group Chair's Assurance Reports
- Template for Committee self-assessment and annual reports – to be produced within 1 month of the end of the financial year

Further details on guidelines and templates are available via http://howis.wales.nhs.uk/sitesplus/861/page/41650 .

The Board's agendas will be focussed on the quality and safety of services with a re-balancing of strategic and operational matters (in favour of the former) and a clearer linkage to strategic goals. Late or otherwise unsatisfactory papers will not be accepted. Tabled papers will not be accepted without the express permission of the Chair. The importance of the Board having high quality, accurate and timely reports and supporting material, on which to take informed decisions is critical to the impact of the Board's effectiveness.

1.8 Board Assurance Framework (BAF)

The Board must assure itself that the whole organisation is operating effectively and meeting its strategic goals. It does this through its governance structures and internal management controls, which provide assurance that systems are operating as they should and the strategic goals and objectives are being delivered. The Board Assurance Framework was approved by the Audit Committee in December 2015. The document has been further updated and is presented at Appendix 4.

1.9 Corporate Risk Register

The Audit Committee approved an updated version of the Corporate Risk Register in December 2015 which is available on the Board's public website. Each individual risk is scrutinised by the Board Committee to which it has been assigned and an updated Register will be brought back to the Board for ratification in May.

1.10 Board Committees

1.10.1 During 2014 the Board completed a review of its committee structure. Following this, a new structure was put in place with effect from 1.1.15, on the understanding that the revised arrangements would be evaluated after six months. This commitment was re-stated in the Board Governance 100 Day Plan as part of the programme of reporting following the Board being placed in Special Measures in June 2015. The evaluation was carried out during the summer of 2015 and its recommendations resulted in the revised committee arrangements set out in this paper. The following diagram illustrates the proposed new structure:

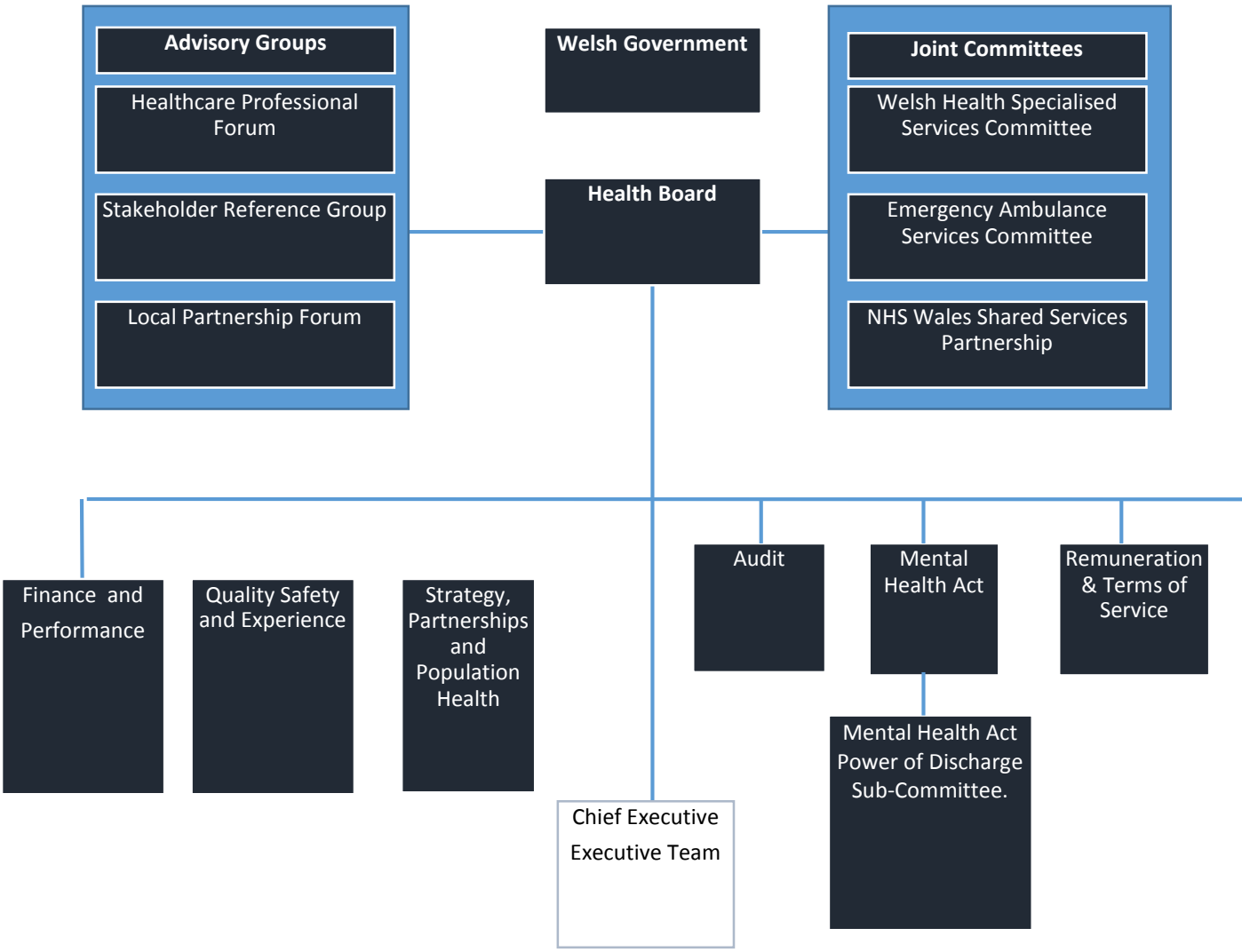


Fig.1 Proposed Committee Structure

A key component of the revised committee arrangements is the proposal to stand down the Integrated Governance Committee (IGC), re-instate its sub-committees as full committees of the Board and introduce a new Committee Business Management Group as described in section 1.10.4.

1.10.2 In addition to committee related templates as detailed in section 1.7.2, revised terms of reference and an associated 'route planner' are included at Appendix 5. The route planner maps out the main business items to be considered by specific committees as well as the Board itself. It aids the effectiveness of scrutiny by facilitating tracking and avoiding duplication.

1.10.3 Committee Advisers

Following the 2014 committee structure review, the role of Committee Adviser was developed as a 12 month pilot. This was to address the skills and capacity gaps identified at the time. An evaluation was duly completed which identified that the gaps had been met by the appointment of new independent members and the role of

Committee Adviser was stood down with effect from 31.12.15. Former Committee Advisers have been invited to express an interest in contributing to the effectiveness and capacity of the Board in other ways in the future.

1.10.4 Committee Business Management Group (CBMG)

It is proposed that the IGC is stood down as a committee, although its key role in managing and integrating the interdependent business of the Board's main committees will continue and be strengthened through the formation of the Committee Business Management Group. Finance & Performance (F&P) Committee, Strategy, Partnerships and Population Health Committee (SP&P) and the Quality, Safety & Experience (QS&E) Committee will report directly to the Board. The CBMG has been established comprising the Chairs and lead Directors of the Audit, F&P, QS&E and SP&P Committees. It is supported by the office of the Board Secretary. The CBMG will have oversight and responsibility for the management and co-ordination of the agendas for F&P, QS&E and SP&P and will collectively sign these off on a rolling basis three months in advance of the respective committee meetings. The CBMG will also be responsible for ensuring that the business of the three committees is co-ordinated to avoid both duplication and 'orphan' items. In addition, it will ensure that the committees' agendas properly and fully in corporate workforce issues and those of information governance. The CBMG met in shadow form for the first time in January 2016, chaired initially by the Chairman of the Health Board, to support the proposed changes to the Committee structure.

The role of the CBMG is to:

- Coordinate agenda setting and cycles of business
- Take account of interdependencies between Committees and avoid duplication or omission of issues
- Share best practice between Committees of the Health Board
- Ensure workforce issues and information governance matters are considered by the appropriate Committee.

CBMG terms of reference are included at Appendix 6. The Group will meet monthly for the first 3 months, with the expectation that it will then meet no less than quarterly throughout the year. This is an internal working group and as such will not meet in public.

1.10.5 Audit Committee

The role of the Audit Committee is to:

- Advise and assure the Board on whether it has an effective system of assurance in place to support its decision making and in discharging its accountabilities for securing the achievement of its strategic goals
- To review the Board Assurance Framework and Corporate Risk Register and advise where appropriate on how they may be strengthened and developed.

The Audit Committee will meet quarterly, plus an additional meeting will be held to approve the Board accounts. The Audit Committee is not held in public, in line with the advice received from Welsh Government in 2010. However, the approved minutes are routinely published on the Health Board's website.

1.10.6 Quality, Safety and Experience Committee (QS&E)

The role of the QS&E Committee is to:

- Advise the Board on the discharge of its responsibilities with regard to quality, safety and patient experience
- Assure the Board in relation to arrangements for the safeguarding of children and vulnerable adults
- Advise the Board with regard to progress against the Health & Care Standards in Wales which inform the Annual Quality Statement.
- Approve relevant policies on behalf of the Board

The QS&E Committee will meet monthly in public, at an appropriate time interval prior to the Board meeting, to allow detailed scrutiny of the quality dimensions of the Integrated Quality and Performance Report (IQPR) beforehand.

1.10.7 Finance and Performance Committee (F&P)

The role of the F&P Committee is to:

- Advise and assure the Board on the discharge of its responsibilities with regard to its current and budget, forecast financial position and performance management
- Assure the Board in relation to capital expenditure
- Assure the Board in relation to aspects of information governance and the provision of informatics including the review of major IT systems
- Assure the Board in relation to workforce performance indicators
- Approve relevant policies on behalf of the Board

The F&P Committee will meet monthly in public, at an appropriate time interval prior to the Board meeting, to allow detailed scrutiny of the finance and performance dimensions of the IQPR beforehand.

1.10.8 Strategy, Partnerships and Population Health Committee (SP&P)

The role of the SP&P Committee (formerly known as the Strategy, Planning & Partnerships Sub-Committee) is to:

- Advise and assure the Board on the discharge of its responsibilities in respect of the development and implementation of the Integrated Medium Term Plan (IMTP)
- Advise and assure the Board with regard to workforce planning in support of its published strategies and plans
- Assure the Board with regard to the adequacy and effectiveness of partnership arrangements to facilitate it meeting the health needs of the population of North Wales and reducing health inequalities
- Advise and assure the Board with regard to partnership governance
- Seek and provide assurance on the arrangements for continuous public engagement

- Promote the development of strategic collaboration and alliances with partner organisations
- Approve relevant policies on behalf of the Board

The SP&P Committee will meet no less than bi-monthly in public.

1.10.9 Other Committees

The following Committees and Sub-Committees will be retained, although their terms of reference have been refreshed to ensure consistency of terminology and layout including a more fundamental review of the Mental Health Act Committee and Power of Discharge Sub-Committee in accordance with the regulations. These are included at Appendix 6:

- Charitable Funds Committee – this will continue to meet in public; Charitable Funds Advisory Group (sub-committee) – this will routinely meet in public
- Mental Health Act Committee – this will continue to meet in public
- Power of Discharge Sub-Committee – this will continue to be held in committee due to the patient identifiable nature of the business
- Remuneration and Terms of Service Committee - future meetings will be held in public, with an 'in committee' agenda only when necessary

With the exception of the Chairmanship of QSE (where Marian Jones replaces Jenie Dean), there are no proposed changes to Committee membership until the outcome of the recruitment of Independent Members, which is currently underway, is concluded. This is expected to be completed by April 2016.

1.10.10 Advisory Groups

The Health Board has three Joint Advisory Groups: the Stakeholder Reference Group (SRG), Health Professionals Forum (HPF) and the Local Partnership Forum (LPF) as set out in the Regulations establishing Health Boards in 2009. The groups support the Board in performing its statutory duty to take account of representations made by people who represent the community it serves. Following a review of the Advisory Groups by Ann Lloyd, as part of the Special Measures programme of work, it has become clear that over time the original purpose of the groups have been lost or diluted. Therefore their agendas and operating arrangements are currently being reviewed.

- The SRG will have a refreshed agenda and purpose and its meetings will adopt a workshop approach.
- The HPF will have a revised forward work plan aligned to Board business, so that it can better advise on matters under development.
- The LPF will refresh the style and content of its meetings, to achieve a better balance between its advisory role and its unique role as part of formal negotiations.

To promote better links between the Advisory Groups and committees of the Board the Chairman is considering aligning Advisory Group Chairs with relevant Committees.

1.11 Executive Structures

The Chief Executive has worked with the Executive Directors to review and update the role and function of Executive management meetings. Wednesdays have been established as the day given over to Executive corporate meetings. The Executive Team acts as the mechanism by which the Chief Executive coordinates the management of the organisation. Executive Team meetings have a key role in collectively agreeing Board papers and assuring their quality prior to submission to the Chairman for sign-off.

2.0 Primary Care Governance

The Primary Care Support Unit (PCSU) is responsible for developing the Board's policy in relation to primary care contract development and assurance, and supporting the Area Teams to implement this to deliver improved primary care services for the population of North Wales.

PCSU provides expert advice and guidance to Area Teams, Independent Contractors, other Health Board staff and the Board in relation to the statutory and regulatory requirements associated with the delivery of General Medical Services (GMS), General and Personal Dental Services (GDS / PDS), Optometry and Community Pharmacy services.

The PCSU team manage and monitor all aspects of the contracts, including both administrative and clinical governance elements to ensure compliance with the appropriate contractual frameworks. This includes addressing contract performance issues to ensure that service standards meet the Board's requirements and expected outcomes, taking remedial contractual action as required, based upon advanced knowledge of primary care contractual frameworks and regulations.

The PCSU coordinates and administers a number of working groups with input from senior staff from the Area Teams in relation to

- Liaison and negotiation – e.g. Local Medical Committee, Local Dental Committee, North Wales Practice Managers Group
- Internal contract management - including GMS and GDS contractual appeals process which, on the rare occasions that appeals arise, requires an Independent Member Panel at Stage 3 (see Appendix 7)
- Quality and safety of primary care services – including addressing performance concerns
- Strategic links – e.g. All Wales Directors of Primary Care Group
- Local Assessment Panel (GP sustainability)

Recommendations from PCSU working groups are then reported to primary care operational groups that have been established in each of the 3 Area Teams.

2.1 Primary Care Panel

The Board also has in place a Primary Care Panel chaired by the Chief Operating Officer to

- Consider and make decisions regarding GMS contractual variations on behalf of the Board
- Consider and make decisions regarding GDS & PDS contractual variations on behalf of the Board
- Consider and make decisions regarding pharmaceutical applications on behalf of the Board
- Consider and make recommendations regarding new contracts to the Board.
- Reporting the decision of the Primary Care Panel for information to the Strategy, Partnerships & Population Health (SPP) Committee
- Preparing new contracts for Board approval

2.2 Primary Care Transformation Group

A Primary Care Transformation Group, chaired by the Chief Operating Officer, has been established to coordinate the Health Board's strategic and operational plans, thus supporting the maintenance and development of a robust and sustainable primary, community and social care service for the people of North Wales

The Primary Care Transformation Group will:

- Support the development and implementation of the Health Board's Primary Care Strategy.
- Monitor the Health Board's progress against the Welsh Government 'Primary Care Plan for Wales'.
- Oversee the Health Board's development of a 'Planned Primary Care Workforce' in line with Welsh Government expectation
- Support the development of clusters as the focus for innovative and sustainable models of integrated primary, community and social care.
- Ensure the Health Board's priorities and three year plans are aligned with cluster priorities and action plans.
- Oversee the development and implementation of a Primary Care Estate Strategy
- Monitor the use of the Primary Care monies ensuring all the funding available is used to support and develop Primary Care.
- Develop appropriate performance and outcome measures to monitor progress at cluster and area level.

- Report to the appropriate Board Committee on progress in relation to these matters.

2.3 Primary Care Strategy

The Board has identified the need to have a comprehensive primary care strategy and improvement plan, which addresses population need and provides more care closer to home, optimising the skills of the workforce and realigning resources. This programme of work is being overseen by the Strategy, Partnership & Population Health Committee on behalf of the Board.

APPENDIX 1 - Standards of behaviour for Board members and meeting etiquette

Standards of behaviour for Board members:

In all our activities we must exemplify the high standards of behaviour we expect from others and hold true to our values and commitments. This means we will:

- Uphold the Nolan principles
- Prepare thoroughly for meetings
- Adhere to our Board etiquette
- Look beyond written intelligence to develop an understanding of the daily reality for patients and staff
- Invest time in appropriate activities to improve our individual and collective performance
- Invest time and energy in activities and behaviours which help to build effective working relationships
    - E.g. get to know others individually and at a personal level, understanding differences will help us adapt style and approach to ensure challenge is heard
    - Verbally praise differences and the thorough consideration of options
    - Appreciate as well as criticise
    - Use empathy and information search in equal doses.
    - Practice active listening skills
    - Work together through issues and dilemmas
- Respond positively to any requests for comments or development work on strategies and plans
- Uphold collective board decisions both in public and private regardless of any personal reservations and opinions
- Respect boundaries between our own roles and those of others, channelling requests for information and action through appropriate routes

At all times there should be mutual trust, respect and honesty between Board members

Board Meeting Etiquette:

Before a meeting:

- Understand the purpose of the meeting and your role in it
- Review the papers; request any further information in advance; make notes, questions and suggestions
- Arrive on time

During the meeting:

- Declare any conflicts of interests at the start or as soon as they arise
- Stay focused on the agenda to help make the most of the time available – keep comments relevant and concise
- Direct contributions through the Chairman
- Listen to and support your fellow Board members; do not interrupt; be constructive with your comments/ criticism and tolerant of diverse points of view
- Understand that conflicts can be a side effect of reaching consensus
- Attend the entire meeting

After the meeting:

- Undertake any actions allocated to you during the meeting in a timely manner
- Recognise and respect any confidences and sensitive matters
- Remember that decisions are taken collectively by the Board and that responsibility is also collective
- Reflect upon the meeting – did the Board make the best use of time and were the right people there?

Appendix 2 - BCU Health Board Cycle of Business

	Jan - Long (L)	Feb - Short (S)	Mar - L	Apr - S	May - L	Jun - S	Jul - L	Aug - S	Sept - L +AGM (2 sep. meetings)	Oct - S	Nov - L	Dec - S
Opening Business												
Chair's Introductory Remarks	x	x	x	x	x	x	x	x	x	x	x	x
Apologies for absence	x	x	x	x	x	x	x	x	x	x	x	x
Declarations of interest	x	x	x	x	x	x	x	x	x	x + AGM mins	x	x
Previous Minutes for Approval and Action Log	x	x	x	x	x	x	x	x	x	x	x	x
Indicative Consent Business												
Annual Accounts									x			
Annual Board cycle of business		x										
Annual Governance Statement									x			
Annual Quality Statement									x			
Annual reports from WHSSC/EASC and NWSSP											x	
Annual Review of Standing Orders									x			
Board Assurance Framework		x										

	Jan - Long (L)	Feb - Short (S)	Mar - L	Apr - S	May - L	Jun - S	Jul - L	Aug - S	Sept - L +AGM (2 sep. meetings)	Oct - S	Nov - L	Dec - S
Consent business continued												
Charitable funds audited accounts and annual report												
Civil Contingencies Annual Report					x							
Committee and Advisory Group Annual Reports (including Audit)							x					
Committee and Advisory Group Chairs Assurance Reports												
Corporate Risk Register	x						x					
Documents signed under seal						x						x
Health & Safety Annual Report											x	
MHA Section 12(2) doctors and approved clinicians												
Minutes/assurance reports for information (CHC Board to Board, EASC, WHSCC , NWSSP)												
Risk Management Strategy				x								
Safeguarding Annual Report											x	

Strategic Equality Plan			x									
	Jan – Long (L)	**Feb – Short (S)**	**Mar – L**	**Apr – S**	**May – L**	**Jun – S**	**Jul – L**	**Aug – S**	**Sept - L +AGM (2 sep. meetings)**	**Oct – S**	**Nov – L**	**Dec – S**
Consent business continued												
Tissue and Organ Donation Annual Report											x	
Welsh Language Annual Report									X			
Other matters												
Annual Audit Report/WAO Structured Assessment Feedback	x											
Dignified Care/Older people's services annual update											x	
Director of Public Health Annual Report - *Additional items to be added on health improvement and inequality											x	
Engagement Strategy					x							
Finance report	x	x	x	x	x	x	x	x	x	x	x	x

Financial Budget			x									
	Jan – Long (L)	**Feb – Short (S)**	**Mar – L**	**Apr – S**	**May – L**	**Jun – S**	**Jul – L**	**Aug – S**	**Sept - L +AGM (2 sep. meetings)**	**Oct – S**	**Nov – L**	**Dec – S**
Other matters continued												
Financial Strategy			x									
Health and Care Standards							x					
Health Board Annual Report									x			
IMTP			x				x			x		
Infection prevention and control					x						**x**	
Integrated Quality & Performance Report	x	x	x	x	x	x	x	x	x	x	x	x
Mental Health Strategy					x							
Mental Health Assurance Reports (x 2) per year) (Including Tawelfan/Ockenden seasonal plan)			x		x		x		x		x	

Primary Care Strategy			x									
Prison health					x						x	
	Jan – Long (L)	**Feb – Short (S)**	**Mar – L**	**Apr – S**	**May – L**	**Jun – S**	**Jul – L**	**Aug – S**	**Sept - L +AGM (2 sep. meetings)**	**Oct – S**	**Nov – L**	**Dec – S**
Other matters continued												
Putting Things Right Annual Report / Ombudsmans Annual Letter									x			
Special Measures Progress Reports		x		x		x		x		x		x
Staff Survey and Leadership Development					x						x	
Closing Business												
Arrangements for next meeting	x	x	x	x	x	x	x	x	x	x	x CHC	x
Summary of In Committee Board business to be reported in public	x	x	x	x	x	x	x	x	x	x	x	x
Summary of information circulated since last meeting	x	x	x	x	x	x	x	x	x	x	x	x

Ad hoc business (to be taken as appropriate)												
Business Cases	x	x	x	x	x	x	x	x	x	x	x	x
	Jan – Long (L)	**Feb – Short (S)**	**Mar – L**	**Apr – S**	**May – L**	**Jun – S**	**Jul – L**	**Aug – S**	**Sept - L +AGM** **(2 sep. meetings)**	**Oct – S**	**Nov – L**	**Dec – S**
Ad hoc business continued												
Primary Care Contracts (new awards)	x	x	x	x	x	x	x	x	x	x	x	x
Research & Development	x	x	x	x	x	x	x	x	x	x	x	x

APPENDIX 3 - Board Coversheet incorporating guidance notes

Board Paper *Insert Board meeting date* **Item** *Corporate Affairs Team to insert*	GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board ***To improve health and provide excellent care***

Title:	*(This should match the title on the paper)*
Author:	*(Title, first name, last name and job title)*
Responsible Director:	*(Title, first name, last name and job title)*
Public or In Committee	*(State which. Most papers will be public - justification must be provided for any paper to be treated as confidential in committee)*
Strategic Goals	*(Indicate how the subject matter of this paper supports the achievement of BCUHB's strategic goals –tick all that apply)* 1. Improve health and wellbeing for all and reduce health inequalities 2. Work in partnership to design and deliver more care closer to home 3. Improve the safety and outcomes of care to match the NHS' best 4. Respect individuals and maintain dignity in care 5. Listen to and learn from the experiences of individuals 6. Use resources wisely, transforming services through innovation and research 7. Support, train and develop our staff to excel.
Approval / Scrutiny Route	*(State whether this paper has had prior scrutiny e.g. by a committee or Executive Group and be clear why it needs to come before the Board. Note any consultations that have taken place on the subject matter of the paper, plus any involvement of partners, patients, service users, and the wider community)*
Purpose:	*(State the purpose of the paper i.e. reasons for presenting it to the Board/Committee).*
Significant issues and risks	*(Briefly list significant points to draw to the Board's attention regarding the purpose of the paper. Highlight any significant risks or impacts e.g quality, safety, legal, equality or financial)*

Equality Impact Assessment	*(If no EqIA carried out, please briefly explain why. EqIA is required where a change of policy or direction is envisaged and/or where budgets are being reduced. It is particularly important that the biggest, most strategic decisions are subjected to an EqIA – see http://howis.wales.nhs.uk/sitesplus/861/page/47193)*
Recommendation/ Action required by the Board	*(A recommendation to the Board in the format 'The Board is asked to...' e.g note for information, endorse, ratify or approve a particular course of action. This recommendation must match that made in the paper itself)*

Disclosure:
Betsi Cadwaladr University Health Board is the operational name of Betsi Cadwaladr University Local Health Board

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

BOARD ASSURANCE FRAMEWORK

2016

BOARD ASSURANCE FRAMEWORK

Contents

1. Introduction

The Board must assure itself that the organisation is operating effectively and meeting its strategic goals. BCUHB does this through its governance structures and internal management controls, which provide assurance that systems are operating as they should and the strategic goals and objectives are being delivered.

Betsi Cadwaladr University Health Board (BCUHB) core purpose is *"to improve health and deliver excellent care"* which is supported by a vision to:

- Improve the health of the population with a particular focus upon the most vulnerable in our society;
- Develop an integrated health service which provides excellent care delivered in partnership with the public and other statutory and third sector organisations;
- Develop our workforce so it has the right skills and operates in a research rich learning culture.

Our 7 Strategic Goals:

- Improve health and wellbeing for all and reduce health inequalities;
- Work in partnership to design and deliver more care closer to home;
- Improve the safety and outcomes of care to match the NHS' best;
- Respect individuals and maintain dignity in care;
- Listen to and learn from the experiences of individuals;
- Support train and develop our staff to excel;
- Use resources wisely, transforming services through innovation and research.

The Strategic Goals form an important statement of what the Board aspires to achieve. These goals will form the backdrop and framework for the development of the Health Board's Integrated Medium Term Plan and were approved by the Board at their public meeting in October 2015. These Strategic Goals will be shared widely with staff and stakeholders.

The Well being of Future Generations (Wales) Act 2015 will require Health Boards to set local well being goals against the national well being goals. This will require a review of the Health Board's strategic goals to ensure alignment in due course.

2. Purpose

A Board Assurance Framework (BAF) is a significant tool in helping the Board to understand the implementation of its overall strategy in the context of risk management. In its simplest form the Board Assurance Framework sets out:

- The Board's strategic goals;
- The risks to achieving them;
- The controls and assurance mechanisms that have been put in place to manage risk and deliver the goals.

The BAF provides a process that enables the health board to focus on the risks it must address in order to achieve its most important strategic goals. It maps out the key controls in place to manage those risks as well as how the Board gains sufficient assurance about their effectiveness.

It is a key tool for the Board to discharge its overall responsibility for internal control.

The BAF is designed to provide the Health Board with:

- a simple but comprehensive method for the effective and focused management of the principal risks that arise in meeting strategic goals;
- a structure for the evidence to support the Annual Governance Statement and Annual Quality Statement;
- simplified Board reporting and prioritisation, which in turn supports effective performance management;
- a means of reporting key information to the Board;
- identification of the organisations strategic goals that might be at risk because of inadequacies in the operation of controls, or where the organisation has insufficient assurance;
- assurances about where risks are being managed effectively and that goals and objectives are being delivered;
- a means for the Health Board to determine where to make the most efficient use of resources and address the issues identified in order to improve quality and safety of care.

The BAF is a “dynamic document”. It seeks to identify where key controls are in place and whether assurances are sufficient to mitigate risks of non-delivery. At the same time, it can provide positive assurance where risks are being managed effectively and goals and objectives are being delivered. This allows the Board to determine where to make most efficient use of its resources to improve the quality and safety of care.

The BAF draws out the risks which will be monitored via the Corporate Risk Register. This enables the Board and its Committees to monitor and scrutinise actions intended to mitigate those risks ensuring that the business conducted is risk based.

3. Risk Management

The Health Board’s risk management process provides a structure for identifying and managing risks at all levels in the organisation. There are three levels at which risks may be identified, managed, controlled and monitored, these being:

- Corporate
- Strategic
- Operational

Depending on the risk and where it can be managed, monitored and controlled, will depend on whether it requires escalation.

The Risk Register

The Board will adopt a single format for recording, measuring and assessing risks at all levels. The format is consistent with good practice advised by the Good Governance Institute making the risk register accessible and straight forward. DATIX will be used to record all risks within a single repository to improve escalation and de-escalation of risks and visibility at all levels. The risk register template being populated all levels across the health board is attached as **Annex 1**. This register will be reported at 3 levels as detailed below:

Corporate Risk Register

The Corporate Risk Register identifies the significant risks directly associated with delivery of the Health Board's Integrated Medium Term Plan which threaten the achievement of strategic goals and objectives. It also includes significant operational risks that have been escalated.

By focusing on these principal risks, the Board's assurance committees can give priority to routinely reporting on the current high level risk issues to the Board. This will ensure that risk management becomes firmly embedded as a Board responsibility. In addition to providing opportunities to improve the effectiveness of management, this will provide the evidence to support the Annual Governance Statement.

The Corporate Risk Register will identify in more detail the current controls and the further actions planned to achieve the target risk score.

Strategic Risk Registers

Each Board level Director will be responsible for ensuring the development and maintenance of a strategic risk register which reflects their responsibilities and accountabilities. The Directors are responsible for reviewing and updating their strategic risk registers escalating and deescalating risks as appropriate in line with the Board's risk appetite.

In addition all Directors will determine the establishment of a hierarchy of operational risk registers to support their strategic risk registers.

Operational Risk Registers

Area Directors, Secondary Care Director, Director of Mental Health and Director of Estates and Facilities will be responsible for ensuring the development and maintenance of operational risk registers which reflect their responsibilities and accountabilities. The Directors are responsible for reviewing and updating their strategic risk registers escalating and deescalating risks as appropriate in line with the Board's risk appetite.

4. Risk Appetite

The Health Board cannot achieve its strategic goals without taking risks.

The Board has considered its risk appetite regarding the risk it is prepared to accept or tolerate in the pursuit of its strategic goals. The Board recognises that this is not a single fixed concept. The Board has worked to define its risk appetite and appreciates that there will be a range of appetites for different risks which need to align and these may change over time.

4.1 Risk Appetite Statement

"The Health Board recognises that its long term sustainability depends upon the delivery of its strategic goals and its relationships with its patients, the public and strategic partners.

The Health Board will not accept risks that materially impact on patient safety.

The Health Board takes a cautious view regarding the risks it is prepared to take in terms of financial control and regulatory compliance, preferring "safe delivery options" with a low degree of inherent risk.

However the Health Board has greater appetite to pursue innovation and challenge current working practices and reputational risk in terms of its willingness to take opportunities where positive gains can be anticipated, within the constraints of the regulatory environment."

The risk appetite takes into account the following elements:

	Unacceptable to take risks			Higher willingness to take risks	
	Very Low	Low	Moderate	High	Very High
Quality	←	→			
Reputation	←	→			
Finance		←	→		
Regulation	←	→			

- Quality
  Delivering high quality services is at the heart of the Health Board's way of working. The Health Board is committed to provide consistent, personalised, high quality and safe services, a journey of continuous quality improvement and has an on-going commitment to being a learning organisation. This means the Health Board is averse (low appetite) to risks that could result in poor quality and safe care, non-compliance with standards of clinical, professional practice or risks which jeopardise compliance with its statutory duties for quality and safety.

- Reputation
  The Health Board will maintain high standards of conduct, ethics and professionalism to ensure a high reputation of the Board is maintained. This

means the Health Board is averse (low appetite) to risks or circumstances that could put its reputation or that of the NHS in jeopardy, or could lead to a loss of confidence by the public, partners, staff and Welsh Government.

- Finance
  The Health Board will strive to deliver services within the budgets modelled in our financial plans and will only consider exceeding these constraints if a financial response is required to mitigate risks associated with patient safety or quality of care. This will be undertaken ensuring optimal value for money in the utilisation of public funds. This means the Health Board will tolerate (moderate appetite) risks only in certain circumstances.

- Regulation
  The Health Board places great importance on compliance with regulation and is averse (low appetite) to risks which result in the Board being non-compliant with healthcare legislation, or any of the applicable regulatory framework in which the Board operates. These include any breaches in statute, regulation, professional standards, research ethics, bribery or fraud.

Each risk will be assessed using the scoring evaluation and matrix in **Annex 3** to determine the risk score.

Each of these dimensions has been summarised within the risk scoring and evaluation matrices which the board will use to assess the likelihood and impact scores for each of the risks.

The Health Board has been working to consider and develop its risk appetite and acknowledges that this must be communicated, monitored and updated on a regular basis. This will become an annual cycle of development and will be aligned to the approval of the Health Board's strategic goals and objectives.

4.2 Principal Risks

The Health Board has determined its principal risks to achieving its strategic goals are:

Principal Risk 1: Failure to maintain the quality of patient services
Principal Risk 2: Failure to maintain financial sustainability
Principal Risk 3: Failure to manage operational performance
Principal Risk 4: Failure to sustain an engaged and effective workforce
Principal Risk 5: Failure to develop coherent strategic plans
Principal Risk 6: Failure to deliver the benefits of strategic partnerships
Principal Risk 7: Failure to engage with patients and reconnect with the wider public
Principal Risk 8: Failure to reduce inequalities in health outcomes
Principal Risk 9: Failure to embed effective leadership and governance arrangements

Corporate risks which are identified or escalated will be mapped on an ongoing basis to these principal risks within the BAF.

5. Assurance System

Sources of Assurance

The Health Board needs to gain assurance on the extent to which it is operating effectively and delivering its strategic vision and strategic goals. In particular, assurances need to cover:

a) Compliance with relevant legislation, regulations, standards and other directions and requirements set by the Welsh Government;
b) The reliability, integrity and security of the information collected and used by the organisation;
c) The provision of high quality and safe health care for its citizens and the effective, efficient and economical use of resources.

The Board can receive assurances from a wide range of sources both internal and external to the organisation. These are summarised below.

INTERNAL ASSURANCE

- Internal Audit Reports
- Chair Assurance reports from Board Committees
- Self Assessment against the Health and Care Standards in Wales
- Clinical Audit
- Serious Untoward incident reports
- Feedback, Comments and Complaints monitoring
- Local Counter Fraud work
- Integrated Performance Reports
- Information Governance Toolkit Self Assessment
- Staff Surveys
- Appraisals and Training records
- Fundamentals of Care Audit
- Welsh Risk Pool

EXTERNAL VALIDATION

- External Audit reports and opinions including annual structured assessments of governance arrangements
- Healthcare Inspectorate Wales reports, investigations and spot checks
- Licensing and regulatory body reports
- Welsh Government reports and reviews including Delivery Unit
- Royal College visits and reports
- Deanery visits
- Patient Surveys
- Feedback from national clinical networks
- Health and Safety Executive
- Community Health Council visits
- External Advisors and Peer Reviewers
- Wales Audit Office
- Public Service Ombudsman
- Older Peoples, Children's and Welsh Language Commissioners
- External Benchmarking exercises

The value which the Board receives from external assurance activity should not be under estimated as its role is to validate the effectiveness of the Board's arrangements. External assurance activity within Betsi Cadwaladr University Health Board will be used to provide a level of assurance, both positive and negative, around its systems of control, identify any gaps in systems of control and ensure that relevant and effective action is undertaken to address the identified gaps.
A key vehicle for receiving external assurance will be through the Annual Structured Assessment undertaken by the Wales Audit Office. Alongside this, assurance will be

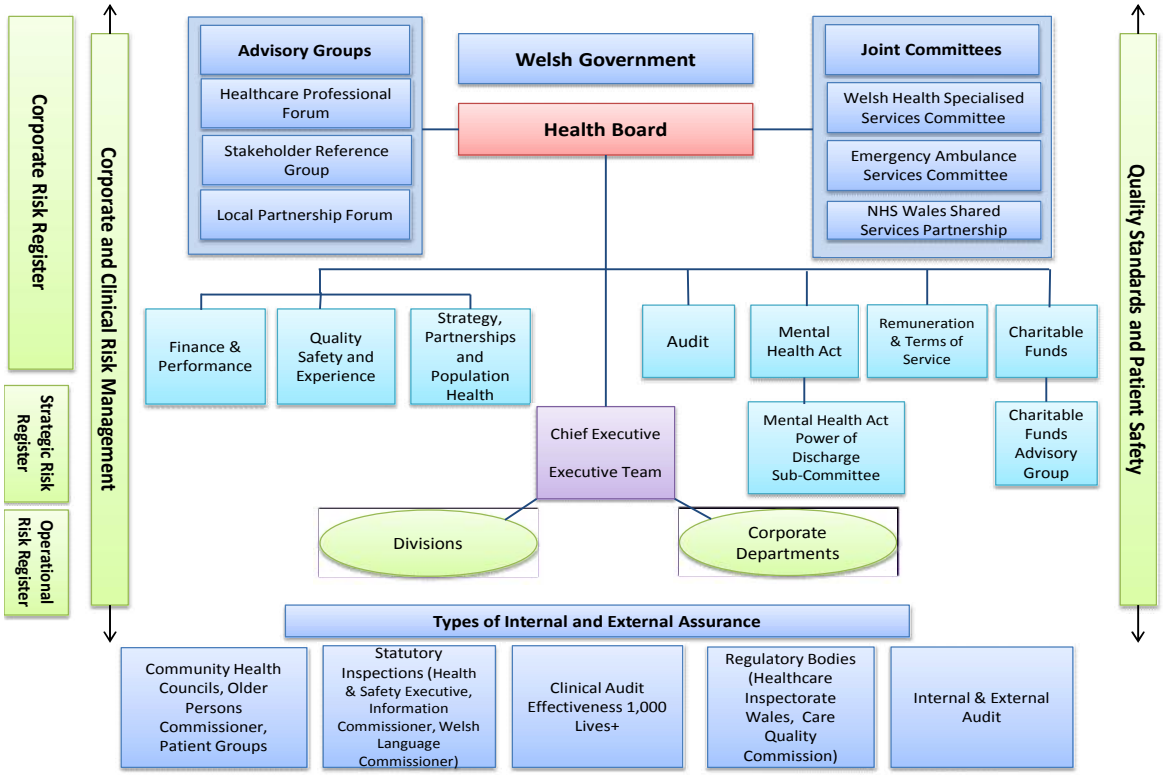
received through the Healthcare Inspectorate Wales reports, reviews and self-assessment.

In order to ensure the Health Board has a robust assurance framework, the Board will seek and receive assurance from a wide range of sources within the organisation, both directly and through the operation of its committees. The Board and its committees will adopt a risk based approach to their cycles of business and work plans to ensure that they receive timely assurance on areas of significant risk exposure.

The Board's committee structure is a key component of the governance and assurance system ensuring that there is appropriate reporting and information flow.

The Committee Business Management Group (CBMG) is an internal working group of the Health Board and will oversee the management and agreement of the agendas for the Board's Finance & Performance, Quality, Safety and Experience, and the Strategy, Partnerships and Population Health Committees. The CBMG will also be responsible for ensuring that the business of these three committees is coordinated to both avoid duplication and 'orphan' items, it will also be responsible for ensuring that the Committees agendas properly and fully incorporate workforce issues and those of Informatics and Information Governance.

The role of the Board and its Committees within the overall governance and assurance framework is set out below:



6. The Assurance Assessment:

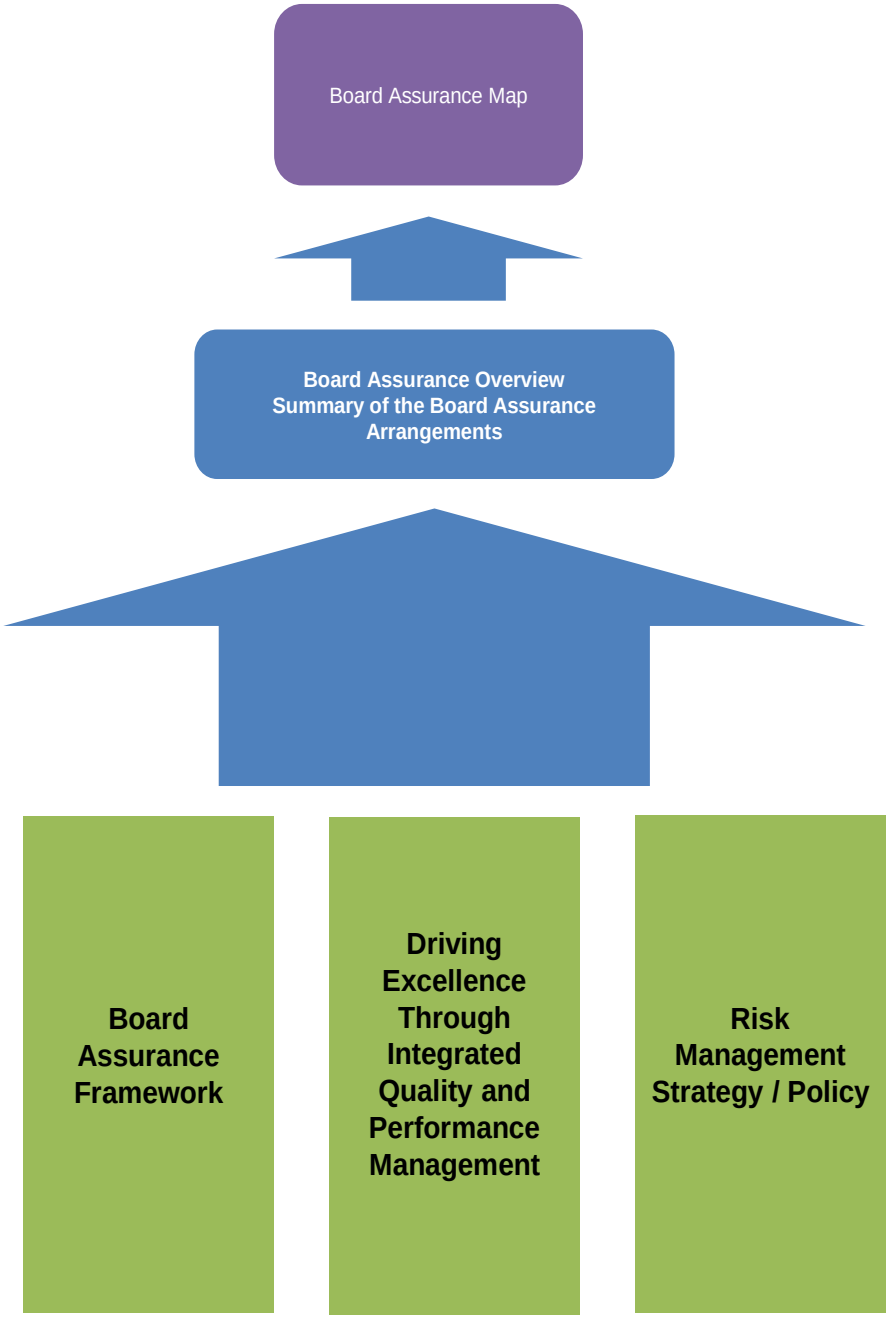
The Health Board has determined that it will set out its risk exposure and map this against the assurances provided by what is described as:

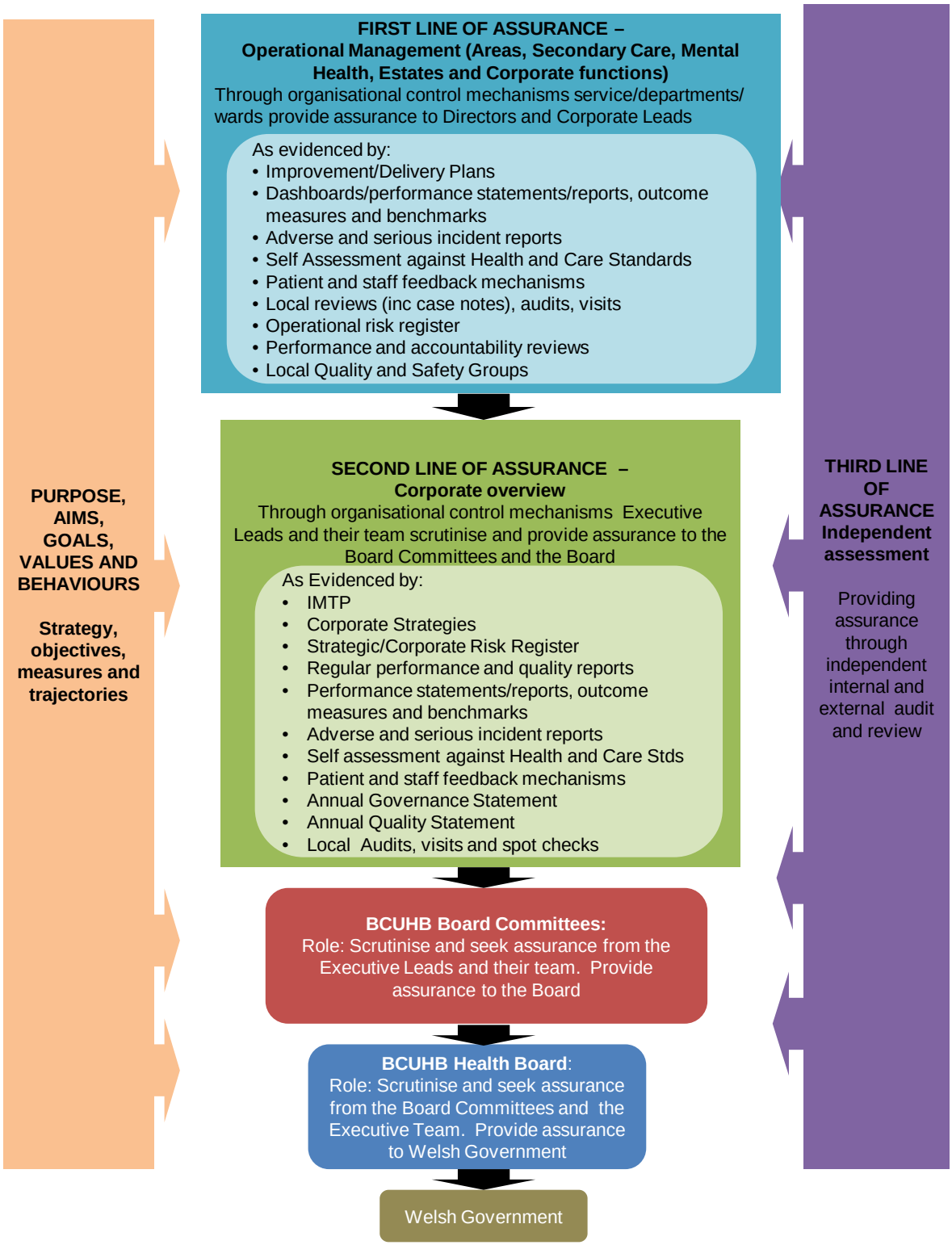
- First line of Assurance
    - **Mitigating Controls in Place** - Systems and processes that are in place and operating that mitigate this risk
- Second line of Assurance
    - **Internal Assurance** - Internal evidence that this risk is being effectively managed (e.g. Board or committee reporting)
- Third line of Assurance
    - **External Assurance** - External evidence/reports that this risk is being effectively managed (e.g. Planned or received internal and external audit reviews)

The Three Lines of Assurance approach is explained in more detail below:

- **First line of Assurance** is an operational area/division or corporate function with frontline staff understanding roles and responsibilities enabling them to be carried out properly and safely, with controls designed into systems and processes. Compliance with policies and procedures both in terms of service delivery and decision making processes are routinely verified from within the area and key risks and control measures identified.
- **Second line of Assurance** incorporates assurance, compliance and risk management at a strategic level, which is overseen by and reports to the Board or one of its committees. The committee structure of Betsi Cadwaladr University Health Board monitors compliance, thereby overseeing the outcomes from the first line of assurance.
- **Third line of Assurance** is external evidence that this risk is being effectively managed (e.g. Planned or received internal and external audit reviews). This includes independent review, overseeing the first two lines of assurance which in turn monitors overall compliance and risk management. This is a key source of assurance for Board Committees, and external organisations such as Welsh Government, and or Health Inspectorate Wales. Review findings are considered by the appropriate committees who can ensure that the appropriate Executive Directors are addressing any identified weaknesses on behalf of the Board.

The diagrams below outline the overall board assurance system (a plan on a page) for the Health Board and incorporating the three lines of assurance methodology:




FIRST LINE OF ASSURANCE –
Operational Management (Areas, Secondary Care, Mental Health, Estates and Corporate functions)
Through organisational control mechanisms service/departments/ wards provide assurance to Directors and Corporate Leads
As evidenced by:
• Improvement/Delivery Plans
• Dashboards/performance statements/reports, outcome measures and benchmarks
• Adverse and serious incident reports
• Self Assessment against Health and Care Standards
• Patient and staff feedback mechanisms
• Local reviews (inc case notes), audits, visits
• Operational risk register
• Performance and accountability reviews
• Local Quality and Safety Groups
SECOND LINE OF ASSURANCE –
Corporate overview
Through organisational control mechanisms Executive Leads and their team scrutinise and provide assurance to the Board Committees and the Board
As Evidenced by:
• IMTP
• Corporate Strategies
• Strategic/Corporate Risk Register
• Regular performance and quality reports
• Performance statements/reports, outcome measures and benchmarks
• Adverse and serious incident reports
• Self assessment against Health and Care Stds
• Patient and staff feedback mechanisms
• Annual Governance Statement
• Annual Quality Statement
• Local Audits, visits and spot checks
BCUHB Board Committees:
Role: Scrutinise and seek assurance from the Executive Leads and their team. Provide assurance to the Board
BCUHB Health Board:
Role: Scrutinise and seek assurance from the Board Committees and the Executive Team. Provide assurance to Welsh Government
Welsh Government
PURPOSE, AIMS, GOALS, VALUES AND BEHAVIOURS
Strategy, objectives, measures and trajectories
THIRD LINE OF ASSURANCE Independent assessment
Providing assurance through independent internal and external audit and review

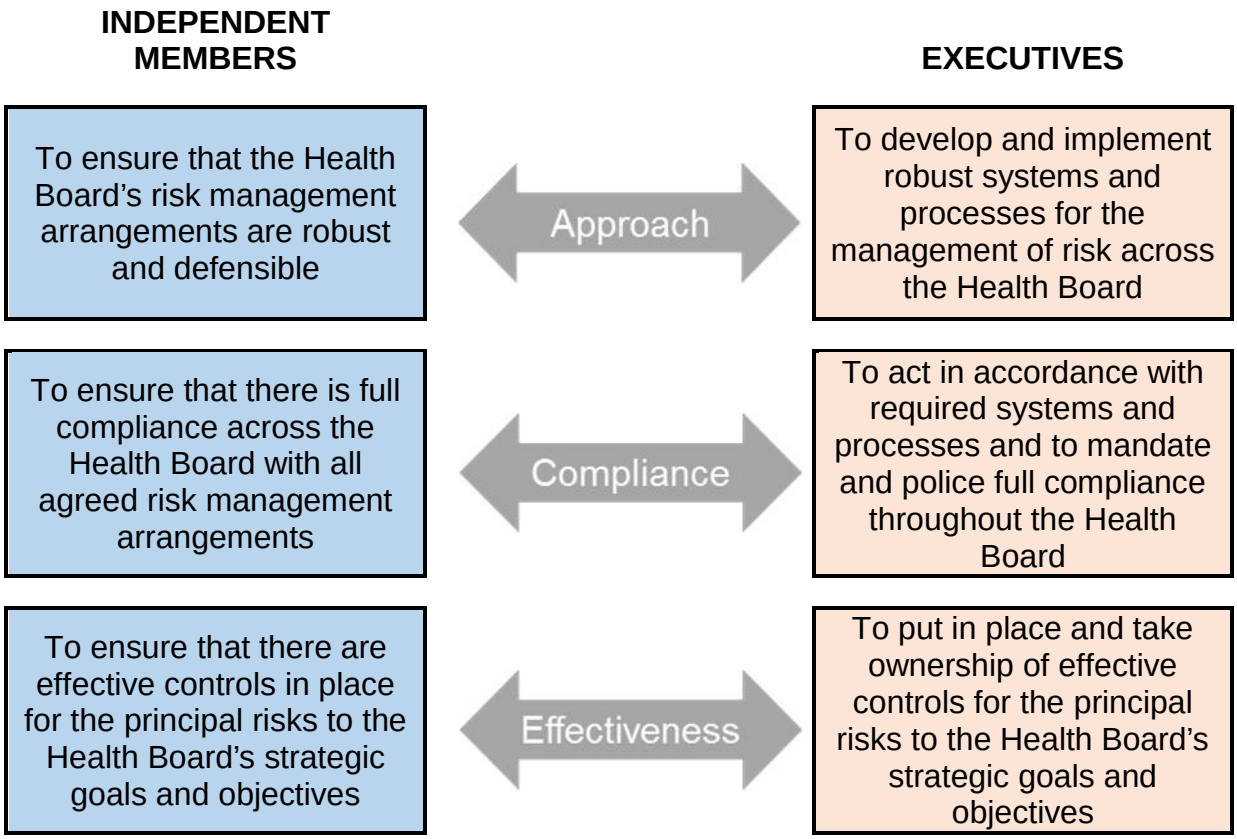
7. Assurance Roles and Responsibilities

7.1 Board

Board leadership is critical to achieving success. Before the Board is able to seek assurance on how well others are delivering on its behalf, it must first establish an effective governance framework that meets the standards set for the NHS in Wales.

It is the collective responsibility of the Board to:

- Determine its strategic direction and related strategic goals;
- Agree its "risk appetite" recognising the interdependencies of goals and the impact of mitigating risks on one may adversely impact on others;
- Agree the key strategic and operational plans that will deliver those goals and which encompass the controls and actions in place to manage the identified risks;
- Monitor delivery through robust performance and assurance arrangements; Ensure that plans are in place to take corrective action where there is minimal assurance that agreed goals will be fully delivered;



7.2 Chief Executive

The Chief Executive is the Accountable Officer with responsibility for assurance arrangements and internal control with the Health Board. The Chief Executive will sign the Annual Governance Statement outlining the level of compliance and this will be published with the Annual Report.

7.3 Board Secretary

The Board Secretary has been delegated responsibility by the Chief Executive to set the governance framework. This includes the following responsibilities:

- Design and develop the Board Assurance Framework;
- Design and develop the Corporate Risk Register;
- Coordinate the cycles of business and work plans of the Board and its Committees to ensure they reflect oversight the identified corporate risks;
- Coordinate the evidence from key sources of internal and external assurance, and ensure appropriate reporting to the Board and its Committees;
- Coordinate the production of the Annual Governance Statement.

7.4 Director of Corporate Services

The Director of Corporate Services has been delegated responsibility by the Chief Executive to be the Health Board's Lead Director for Risk Management. This includes:

- Design and develop the assurance and escalation framework to support the BAF;
- Ensure effective risk management processes are in place within the Health Board.

7.5 Executive Directors and Directors

All Executive Directors and Directors are responsible for ensuring up to date assurance is provided to the Health Board in relation to areas of significant risk exposure that they have lead responsibility for. These will be underpinned by their strategic and operational risk registers.

8. Reporting Structure

8.1 The Board

The overarching Board Assurance Framework will be reviewed annually by the Board to ensure that it continues to be fit for purpose and to coincide with the approval of the Health Board's strategic goals for the forthcoming year and that there are no omissions. Each corporate risk is aligned to a Committee of the Board who will routinely scrutinise the management and mitigation of the risk. Progress against the corporate risks being overseen by the Committee must be reported to the Board as part of the Committee Chairs assurance report.

Throughout the year the cycle of business for the Board and its Committees will be aligned to the board's strategic goals and corporate risks. This will be explicit within the front covers of all Board and its Committee papers.

8.2 Audit Committee

The Audit Committee will review the board assurance framework annually as part of its work in support of the annual governance statement.

- The Audit Committee will advise and assure the Board on whether it has an effective system of assurance in place to support its decision making and in discharging its accountabilities for securing the achievement of its strategic goals.
- Review the Board Assurance Framework and Corporate Risk Register and advise where appropriate how they may be strengthened and developed.

The committee will review the format of the Assurance Framework to ensure that it remains relevant and effective for the organisation. In this way, the Committee can provide assurance that the framework concentrates on high risk areas where the situation needs monitoring.

8.3 Committee Business Management Group (CBMG)

The CBMG will comprise of the Chairs of Audit, Finance and Performance, Quality, Safety and Experience, Strategy, Partnerships and Population Health Committees. The CBMG will be supported by the Board Secretary and have oversight and responsibility for the management and agreement of the agendas for the above three committees. The CBMG will also be responsible for ensuring that the business of the three committees is coordinated to avoid both duplication and 'orphan' items.

The role of the CBMG is to:

- Coordinate agenda setting and cycles of business
- Take account of interdependencies and avoid duplication or omission
- Share best practice
- Ensure workforce issues and information governance matters are considered by the appropriate Committee.

8.4 Board Committees

In line with current arrangements, each corporate risk is designated to a Board Committee which has responsibility on behalf of the Board to seek assurance that those risks are being managed in accordance with the agreed risk appetite and approved plans.

9. Operational Process for Board Assurance

Against each strategic goal, there is a need for an assessment of the risks of achievement as an integral aspect of the Health Board's planning process. The BAF shown at **Annex 2** shows the alignment between the Health Board's strategic goals and areas of high risk which require monitoring. It sets out the risk owner at Executive level, the cross reference to the Corporate Risk Register, the links to the Health Board's strategic goals, mitigating controls, sources of internal and external assurance and where there are any gaps. Each risk will have an initial, current and target risk score. This is assessed using the risk scoring and rating matrices which take account of the likelihood and impact. Details of the classifications and descriptors which will be used to make these assessments are set out in **Annex 3**.

9.1 Each Executive must ensure the corporate risk they have lead responsibility for as set out in the BAF is:

- Aligned to a Board Strategic Goal;
- Has the necessary assurances in place;
- Reviewed and updated;
- Ensure identified gaps in assurance are addressed and actions are developed and reported to appropriate Committees.

9.2 The overall programme of Board and Committee business requires development in such a way that it delivers on the assurance framework:

- The Board will review the BAF annually in conjunction with the review and approval of its Strategic Goals;
- The Board will seek assurance from its committees on the actions being taken to mitigate the corporate risks;
- The Audit Committee will review the BAF bi-annually to ensure it:

    - remains fit for purpose
    - reviews and identifies gaps in assurance
    - to ensure the BAF remains aligned with the CRR and
    - seeks assurances from committees on actions to address those gaps.

- Committees will routinely scrutinise exception reports to address any areas of shortfall identified within the BAF and provide the appropriate assurance or escalation.

Work plans and cycles of business for committees will be aligned to the delivery of the Board's strategic goals, objectives and the management of risk. This programme of work will be the responsibility of the CBMG.

10. References

Academi Wales (2014) *Academi Wales*, *The Good Governance Guide for NHS Wales Boards*

Good Governance Institute and Healthcare Quality Improvement Partnership, (2012) *Good Governance Handbook*

Healthcare Inspectorate Wales and the Wales Audit Office (2013) *An Overview of Governance Arrangements Betsi Cadwaladr University Health Board, June 2013*,

National Assembly for Wales (2013) *Governance Arrangements at Betsi Cadwaladr University Health Board*, Public Accounts Committee, December 2013

NHS Leadership Academy (2013) *The Healthy NHS Board 2013 – Principles for Good Governance*

Welsh Government (2010a) *Doing Well, Doing Better – Standards for Health Services in Wales*

Wales Audit Office (April 2015) *Governance in the NHS In Wales Memorandum for the Public Accounts Committee*

NHS England (January 2015) Risk Management Policy and Process Guide

Annex 1 – Risk Register Template

Ref No (Link to Board Assured Framework)	Risk Register Ref No	Date Entered onto BCUHB Risk Register	Executive Lead	Risk / Issue (including Impact)	Initial Risk Rating		
					Impact	Likelihood	Score
Current Controls					Residual Risk Rating		
					Impact	Likelihood	Score
					Target Risk Rating		
Further actions to achieve target risk score			**Date to achieve target risk score**	**Board Committee to review risk**	Impact	Likelihood	Score

Annex 2 – Board Assurance Framework Template

BAF Template Framework V2.xlsx

Annex 3 – Risk Scoring and rating matrices

Likelihood score	Likelihood Scoring				
	1	2	3	4	5
Descriptor	Rare	Unlikely	Possible	Likely	Very Likely
Frequency / How likely is it to happen?	This probably will never happen/recur	Do not expect it to happen/recur, but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur, but is not a persisting issue or circumstance	Very likely to happen/recur; possibly frequency

Category	Impact Scoring				
Impact score	1	2	3	4	5
Descriptor	Very low	Low	Moderate	High	Very high
Quality	• Minor reduction in quality in treatment or service • No or minimal effect on patients	• Single failure to meet national standards of quality or treatment or service • Low effect for a small number of patients if unresolved	• Repeated failure to meet national standards of quality of treatment or service • Moderate effect for a small number of patients if unresolved	• Ongoing non-compliance with national standards of quality of treatment or service • Significant effect for numerous patients if unresolved	• Gross failure to meet national standards with totally unacceptable levels of quality of treatment or service • Very significant effect for large numbers of patients if unresolved
Reputational	• Not relevant to organisational goals • No adverse media coverage • No negative recognition from the public	• Minor impact on achieving organisational goals • Low level of adverse media coverage • Small amount of negative public interest	• Moderate impact on achieving organisational goals • Moderate amount of adverse media coverage • Moderate amount of negative public interest	• High impact on achieving organisational goals • High level of adverse media coverage • Negative impact on public confidence	• Organisational goals will not be achieved • National adverse media coverage • Totally loss of public confidence
Finance	• Small loss • Risk of claim remote	• Deficit of £100,000 or less	• Deficit of £100,000 to £500,000	• Deficit of £500,000 to £1m	• Non delivery of strategic goal • Deficit greater than £1m • Failure to meet specification

					• Claims in excess of 1million •
Regulation	• No or minimal impact or breach of guidance/statutory duty	• Breach of statutory legislation	• Single breach of statutory duty • Challenging external recommendations	• Enforcement action • Improvement notice • Multiple breaches in statutory duty • Critical report	• Continued breaches in statutory duty • Prosecution • Severely critical report • Complete system change required

Risk Scoring

Each risk will be rated by taking the likelihood and impact scores and applying to the matrix below

Impact	Very high – 5	**5**	**10**	**15**	**20**	**25**
	High – 4	**4**	**8**	**12**	**16**	**20**
	Moderate – 3	**3**	**6**	**9**	**12**	**15**
	Low – 2	**2**	**4**	**6**	**8**	**10**
	Very low - 1	**1**	**2**	**3**	**4**	**5**
		1	**2**	**3**	**4**	**5**
		Rare	Unlikely	Possible	Likely	Very likely
		Likelihood				

APPENDIX 5 - BOARD and COMMITTEE BUSINESS ROUTE PLANNER

Agenda Items	Committee	Board
Accessible Healthcare Standards	QSE	
Accounting annual progress review	A	
Annual Accounts	A	√
Annual Audit Report/Structures Assessment Feedback	A	√
Annual budget principles and budget management strategy	F&P	√
Annual Governance Statement	A	√
Annual Quality Statement	QSE/A	√
Annual Report of the Health Board	A	√
Approved Clinicians and Section 12(2) Doctors	MHAC	√
Audit Committee Annual Report (inc self-assessment)	A	√
Audit tracker tool reports (internal and external)	A	
Auditor General's plans and reports	A	
Board Assurance Framework	A	√
Business Cases	F&P	√
Caldicott	QSE	
Capital developments (in line with service plan)	F&P	
Capital Programme Report	F&P	
Carer's Measure	SPP	
Chair's Assurance Reports	-	√
Charitable Funds Accounts	CFC/A	
Charitable funds audited accounts and annual report	CFC	√as Trustees
Charitable funds budget for forthcoming year	CFC	
Charitable Funds Committee Annual Report (inc self-assessment)	CFC	√
Charitable funds finance report	CFC	
Charitable funds ISA260 report	CFC	
Civil contingency and business continuity update	SPP	√ [Civil Contingencies Annual Report]
Clinical Audit Plans	A	
Clinical Audit Progress Reports	QSE	
Clinical Services Strategy	SPP	√
Community Health Protection Group Annual Assurance Report	QSE	
Consultation responses	SPP	
Continuing Healthcare Quarterly Report	QSE	

Corporate Health at Work	SPP	
Corporate Risk Register (overall)	A	√
Corporate Risks allocated to F&P	F&P	
Corporate Risks allocated to QSE	QSE	
Corporate Risks allocated to SPP	SPP	
Counter Fraud Annual Report	A	
Counter Fraud Progress Reports / Workplan	A	
Declaration of interests/gifts & hospitality register review	A	
Deprivation of Liberty Safeguards quarterly report	MHAC	
Dignified Care/Older People's Services annual update	QSE	√
Director of Quality Assurance Report	QSE	
Director of Public Health Annual Report	SPP	√
Discretionary capital	F&P	
Distribution of annual discretionary capital allocation	F&P	
District Nursing Strategy quality monitoring	QSE	
Documents signed under seal	-	√
EASC minutes and annual report	-	√
Engagement Strategy	SPP	√
Equality Update and Strategic Plan	QSE / SPP	√ [Annual]
Estates/capital business cases	F&P	
Expenditure approval requests	CFC	
External Audit Management Letter	A	
External Audit Plan	A	
External Audit Progress Reports	A	
F&P Committee Annual Report (inc self-assessment)	F&P	√
Finance report	F&P	√
Finance Strategy/budget	F&P	√
Financial accounting timetable	A	
Financial Conformance report	A	
Fundraising report	CFC	
Health & Care Standards scrutiny	QSE	√ [Annual]
Health and Safety (inc violence/aggression; estates and workforce)	QSE	
Health and Safety Annual Report	QSE	√
Health Care Records Annual Report	F&P	
Hospital Manager's Update Report	MHAC	
IMHA performance 6 monthly report	MHAC	
Infection Prevention and Control reports	QSE	√

Informatics (including Health Records)	F&P	
Information Governance	F&P	
Integrated Medium Term Plan – development and monitoring	SPP	√
Integrated Quality & Performance Report (quality/finance dimensions)	QSE/F&P	
Internal Audit Annual Plan	A	
Internal Audit Reports and Internal Audit Charter	A	
Investment Manager's portfolio report	CFC	
Junior doctor rota management assurance	F&P	
Listening and Learning quarterly report	QSE	
Local/Public Service Boards report (inc Safer Communities Board and County Forums)	SPP	
Mandatory training – quality issues/monitoring	QSE/F&P	
Mental Health Act and Mental Health Measure report	MHAC	
Mental Health Act Committee Annual Report (inc self-assessment)	MHAC	√
Mental Health Assurance Reports	QSE	√
Mental Health Strategy	SPP	√
NWSSP Committee annual report	-	√
Objective setting for Executives and Very Senior Managers	R&TS	
Partnership arrangements, governance and effectiveness	SPP	
Patient Stories	QSE	
Performance assurance progress reports	F&P	
Performance Management Framework	F&P	
Performance Management of Executives and Very Senior Managers	R&TS	
Policies (relating to area of responsibility)	QSE/F&P/ SPP/CFC/ MHAC/R&TS	
Population Health Strategy	SPP	
Post Payment Verification report	A	
Power of Discharge Sub-Committee terms of reference annual review	MHAC	
Primary Care Contracts (new awards)		√
Primary Care Strategy	SPP	√
Prison Health	SPP	√
Professional registration and revalidation updates	F&P	
Public Health Wales Service Groups Assurance Reports	QSE	
Putting Things Right/Ombudsman Annual Report	QSE	√

QSE Committee Annual Report (inc self-assessment)	QSE	√
R&TS Committee Annual Report	R&TS	
Radiation Protection Annual Report	QSE	
Recruitment and retention strategy	SPP	
Remuneration and terms of services for Executives and Very Senior Managers	R&TS	
Research & Development	QSE	√
Review of Reserves Policy	CFC	
Review of SO's/SFI's and Scheme of Delegation	A	
Risk Management Strategy	A	√
Safeguarding Updates and Annual Report	QSE	√ [Annual]
Section 136 progress report/street triage update report	MHAC	
Shared Services Review of Internal Audit	A	
Special Measures progress reports	-	√
SPP Committee Annual Report (inc self-assessment)	SPP	√
Statutory Supervision of Midwives Annual Report	QSE	
Strategic developments	SPP	
Sustainability Report	A	
Tawel Fan Update		√ [Annual]
Tender Update and waiver reports	A	
Termination payments including Voluntary Early Retirement Scheme	R&TS	
Third Sector Strategy	SPP	
Three Year financial plan	F&P	
Tissue and Organ Donation annual report	QSE	√
Training commissioning	SPP	
WAO Structured Assessment feedback	A	
WAO/HIW Recommendations	A/F&P/QSE	
Welsh Language strategic reports	SPP	√ [Annual]
Welsh Risk Pool Assessment of Concerns/Claims	QSE	
WHSSC minutes and annual report	-	√
Women's Services Updates	QSE	
Workforce & OD strategic overview	SPP	
Workforce flu vaccination update	F&P	
Workforce Health & Wellbeing Report (inc Corporate Health Standard and Staff Survey update)	F&P	√ [Staff Survey and Leadership & Development]

Workforce Policies	F&P	
Workforce Report (different focus each time)	F&P	
Workforce Strategy and Plan (as part of IMTP)	SPP	
Ysbyty Glan Clwyd Redevelopment Updates (quality aspects)	QSE	

Key:

A	Audit Committee
CFC	Charitable Funds Committee
F&P	Finance and Performance Committee
MHAC	Mental Health Act Committee
PoD	Power of Discharge Sub-Committee
R&TS	Remuneration and Terms of Service Committee
SPP	Strategy, Public Health & Partnerships Committee
QSE	Quality, Safety and Experience Committee

Betsi Cadwaladr University Health Board
Terms of Reference and Operating Arrangements

AUDIT COMMITTEE

1. INTRODUCTION

1.1 The Board shall establish a committee to be known as the **Audit Committee**. The detailed terms of reference and operating arrangements in respect of this Committee are set out below.

2. PURPOSE

2.1 The purpose of the Committee is to advise and assure the Board and the Accountable Officer on whether effective arrangements are in place – through the design and operation of the Health Board's system of assurance – to support them in their decision taking and in discharging their accountabilities for securing the achievement of the Boards objectives, in accordance with the standards of good governance determined for the NHS in Wales.

2.2 Where appropriate, the Committee will advise the Board and the Accountable Officer on where, and how, its assurance framework may be strengthened and developed further.

3. DELEGATED POWERS

3.1 The Committee, in respect of its provision of advice and assurance will and is authorised by the Board to: -

3.1.1 comment specifically in its Annual Report upon the adequacy of the Health Board's strategic governance and assurance arrangements and processes for the maintenance of an effective system of good governance, risk management and internal control across the whole of the organisation's activities (both clinical and non-clinical). It is also intended to support the public disclosure statements that flow from the assurance processes, including the Annual Governance Statement and the Annual Quality statement, providing reasonable assurance on:

- the organisation's ability to achieve its objectives;
- compliance with relevant regulatory requirements, standards, quality and delivery requirements and other directions and requirements set by the Welsh Government and others;
- the reliability, integrity, safety and security of the information collected and used by the organisation;

- the efficiency, effectiveness and economic use of resources; and
- the extent to which the organisation safeguards and protects all its assets, including its people.

3.1.2 to ensure the provision of effective governance -by reviewing
- the Board's Standing Orders, and Standing Financial Instructions (including associated framework documents, as appropriate);
- the effectiveness of the Board's Committees
- the accounting policies, the accounts, and the annual report of the organisation (as specified in the Manual for Accounts as issued by Welsh Government), including the process for review of the accounts prior to submission for audit, levels of errors identified, the ISA260 Report and with Management's letter of representation to the external auditors;
- the, Annual Audit Report and Structured Assessment
- financial conformance and he Schedule of Losses and Compensation;
- the planned activity and results of both internal and external audit, clinical audit, the Local Counter Fraud Specialist and post payment verification work (including strategies, annual work plans and annual reports);
- the adequacy of executive and managements responses to issues identified by audit, inspection, external reports and other assurance activity;
- proposals for accessing Internal Audit services via Shared Service arrangements (where appropriate);
- anti fraud policies, whistle-blowing processes and arrangements for special investigations; and
- any particular matter or issue upon which the Board or the Accountable Officer may seek advice.

3.2 The Committee will support the Board with regard to its responsibilities for risk and internal control by reviewing:

- the adequacy of the Board Assurance Framework and Corporate Risk Register;
- all risk and control related disclosure statements, in particular the Annual Governance Statement and the Annual Quality Statement together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board;
- the underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements;
- the policies for ensuring compliance with relevant regulatory, legal and code of conduct and accountability requirements, including declarations of interest and gifts and hospitality; and

- the policies and procedures for all work related to fraud and corruption as set out in Welsh Government Directions and as required by the Counter Fraud and Security Management Service;
- regular tender waiver reports to ensure compliance with the Standing Financial Instructions.

3.3 in carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions. It will also seek reports and assurances from directors and managers as appropriate in response to the recommendations made, monitoring progress via the Audit Tracker tool.

3.4 this will be evidenced through the Committee's use of effective governance and assurance arrangements to guide its work and that of the audit and assurance functions that report to it, and enable the Committee to review and form an opinion on:

- the comprehensiveness of assurances in meeting the Board and the Accountable Officer's assurance needs across the whole of the Health Board's activities, both clinical and non clinical; and
- the reliability and integrity of these assurances.

3.5 To achieve this, the Committees programme of work will be designed to provide assurance that:

- There is an effective Internal Audit function that meets the standards set for the provision of Internal Audit in the NHS in Wales and provides appropriate independent assurance to the Board and the Accountable Officer through the Committee;
- there is an effective counter fraud service that meets the standards set for the provision of counter fraud in the NHS in Wales and provides appropriate assurance to the Board and the Accountable Officer through the Committee;
- work with the Quality, Safety and Experience Committee to ensure that there is an effective clinical audit and quality improvement function that meets the standards set for the NHS in Wales and provides appropriate assurance to the Board and the Accountable Officer;
- there are effective arrangements in place to secure active, ongoing assurance from management with regard to their responsibilities and accountabilities, whether directly to the Board and the Accountable Officer or through the work of the Board's Committees;
- the work carried out by key sources of external assurance, in particular, but not limited to the Health Board's External Auditors, is appropriately planned and co-ordinated and that the results of external assurance activity complements and informs (but does not replace) internal assurance activity;
- the work carried out by the whole range of external review bodies is brought to the attention of the Board, and that the organisation is aware of the need to comply with related standards and

recommendations of these review bodies, and the risks of failing to comply;

- the systems for financial reporting to the Board, including those of budgetary control, are effective; and that the results of audit and assurance work specific to the Health Board, and the implications of the findings of wider audit and assurance activity relevant to the Health Board's operations are appropriately considered and acted upon to secure the ongoing development and improvement of the organisation's governance arrangements.

4. AUTHORITY

4.1 The Committee may investigate or have investigated any activity (clinical and non-clinical) within its terms of reference. It may seek relevant information from any:

- employee (and all employees are directed to cooperate with any legitimate request made by the Committee); and

- other committee, sub-committee or group set up by the Board to assist it in the delivery of its functions.

4.2 It may obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements; and

4.3 It may consider and where appropriate, approve on behalf of the Board any policy within the remit of the Committee's business.

5. ACCESS

5.1 The Head of Internal Audit, the Auditor General and his representatives and the lead Local Counter Fraud Specialist (LCFS) shall have unrestricted and confidential access to the Chair of the Audit Committee and vice versa.

5.2 The Committee will meet with Internal and External Auditors and the nominated LCFS without the presence of officials on at least one occasion each year.

6. SUB-COMMITTEES

6.1 The Committee may, subject to the approval of the Health Board, establish sub-committees or task and finish groups to carry out on its behalf specific aspects of Committee business.

6. MEMBERSHIP

6.1 Members

Four Independent Members of the Board to include a member of the Quality, Safety and Experience Committee.

The Chair of the Organisation shall not be a member of the Audit Committee.

6.2 In attendance

Board Secretary (lead Director)
Executive Director of Finance
Head of Internal Audit
Head/individual responsible for Clinical Audit
Local Counter Fraud Specialist
Representative of Auditor General (External Audit)

The Chief Executive as Accountable Officer should be invited to attend, at least annually, to discuss with the Committee the process for assurance that supports the Annual Governance Statement.

Other Directors/Officers will attend as required by the Committee Chair, as well any others from within or outside the organisation who the Committee considers should attend, taking into account the matters under consideration at each meeting.

6.3 Member Appointments

6.3.1 The membership of the Committee shall be determined by the Chairman of the Board taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government. This includes the appointment of the Chair and Vice-Chair of the Committee who shall be Independent Members.

6.3.2 Appointed Independent Members shall hold office on the Committee for a period of up to 4 years. Tenure of appointments will be staggered to ensure business continuity. A member may resign or be removed by the Chairman of the Board. Independent Members may be reappointed up to a maximum period of 8 years.

6.4 Secretariat

6.4.1 Secretary: as determined by the Board Secretary.

6.5 Support to Committee Members

6.5.1 The Board Secretary, on behalf of the Committee Chair, shall:

- Arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role; and

- Ensure the provision of a programme of development for Committee members as part of the overall Board Development programme.

7. COMMITTEE MEETINGS

7.1 Quorum

7.1.1 At least two Independent Members must be present to ensure the quorum of the Committee, one of whom should be the Committee Chair or Vice-Chair. In the interests of effective governance it is expected that a minimum of two Executive Directors/Board Secretary will also be in attendance.

7.2 Frequency of Meetings

7.2.1 Meetings shall be routinely be held on a quarterly basis.

7.3 Withdrawal of individuals in attendance

7.3.1 The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

8. RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

8.1 Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for ensuring the quality and safety of healthcare for its citizens through the effective governance of the organisation.

8.2 The Committee is directly accountable to the Board for its performance in exercising the functions set out in these Terms of Reference,

8.3 The Committee, through its Chair and members, shall work closely with the Board's other Committees including joint committees/Advisory Groups to provide advice and assurance to the Board through the:

8.3.1 joint planning and co-ordination of Board and Committee business; and

8.3.2 sharing of information

in doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance arrangements.

8.4 The Committee shall embed the corporate goals and priorities through the conduct of its business.

9. REPORTING AND ASSURANCE ARRANGEMENTS

9.1 The Committee Chair shall:

9.1.1 report formally, regularly and on a timely basis to the Board on the Committee's activities via the Chair's assurance report as well as the presentation of an annual report;

9.1.2 ensure appropriate escalation arrangements are in place to alert the Health Board Chair, Chief Executive or Chairs of other relevant committees of any urgent/critical matters that may affect the operation and/or reputation of the Health Board.

9.2 The Committee shall provide a written annual report to the Board and the Accountable Officer on its work in support of the Annual Governance Statement and the Annual Quality Statement, specifically commenting on the adequacy of the assurance framework, the extent to which risk management is comprehensively embedded throughout the organisation, integration of governance arrangements and the appropriateness of self-assessment activity against relevant standards. The report will also record the results of the Committee's self-assessment and evaluation.

9.3 The Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation. In doing so account will be taken of the requirements set out in the NHS Wales Audit Committee Handbook.

10. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

10.1 The requirements for the conduct of business as set out in the Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum

11. REVIEW

11.1 These terms of reference and operating arrangements shall be reviewed annually by the Committee and any changes recommended to the Board for approval.

Date of approval by the Board:-

……

Betsi Cadwaladr University Health Board

Terms of Reference and Operating Arrangements

QUALITY, SAFETY AND EXPERIENCE COMMITTEE

1. INTRODUCTION

1.1 The Board shall establish a committee to be known as the **Quality, Safety and Experience Committee (QS&E).** The detailed terms of reference and operating arrangements in respect of this Committee are set out below.

2. PURPOSE

2.1 The purpose of the Committee is to provide advice and assurance to the Board in discharging its functions and meeting its responsibilities with regard to quality, safety, patients and service user experience of health services.

3. DELEGATED POWERS

3.1 The Committee, in respect of its provision of advice and assurance will and is authorised by the Board to:-

3.1.1 ensure that arrangements for the quality and safety of patient care are in accordance with its corporate goals, stated priorities within the Quality Improvement Strategy and the principle of continuous quality improvement including organisational learning;

3.1.2 ensure the adequacy of safeguarding and infection, prevention and control arrangements;

3.1.3 provide assurance in relation to improving the experience of patients, citizens and all those who come into contact with the Health Board's services, as well as those provided by other organisations' or as part of a partnership arrangement;

3.1.4 seek assurance on the robustness and appropriateness of Health and Safety arrangements across the Health Board including aspects impacting on patient care, quality and safety and experience;

3.1.5 ensure that all reasonable steps are taken to prevent, detect and rectify irregularities or deficiencies in the quality and safety of care provided and in particular that:

- Sources of internal assurance (including clinical audit) are reliable
- Recommendations made by internal and external reviewers are considered and acted upon on a timely basis
- Appropriate review is carried out and corrective action is taken arising from incidents, complaints and claims known collectively as 'Concerns'.

3.1.6 Review achievement against the Health and Care Standards including accessible health care to inform the Annual Quality and Annual Governance Statements;

3.1.7 Seek assurance on the quality and safety of services commissioned from external providers (including care homes) and others who provide a commissioning role on behalf of the Health Board e.g. Welsh Health Specialised Services Committee (WHSSC); Emergency Ambulance Services Committee (EASC).

3.1.8 Review and seek assurance on the appropriateness of the quality indicators defined within the Integrated Quality and Performance Report (IQPR) and scrutinize the quality dimensions contained within the IQPR;

3.1.9 provide advice and assurance to the Board regarding the quality impact assessment of strategic plans as appropriate;

4. AUTHORITY

4.1 The Committee may investigate or have investigated any activity (clinical and non-clinical) within its terms of reference. It may seek relevant information from any:

- employee (and all employees are directed to cooperate with any legitimate request made by the Committee); and

- other committee, sub-committee or group set up by the Board to assist it in the delivery of its functions.

4.2 It may also obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements;

4.3 It may consider and where appropriate, approve on behalf of the Board any policy within the remit of the Committee's business concerning Quality, Safety and Patient Experience matters.

4.4 It will review risks from the Corporate Risk Register that are assigned to the Committee by the Board and advise the Board on the appropriateness of the scoring and mitigating actions in place;

5. SUB-COMMITTEES

5.1 The Committee may, subject to the approval of the Health Board, establish sub-committees or task and finish groups to carry out on its behalf specific aspects of Committee Business.

6. MEMBERSHIP

6.1 Members

Four Independent Members of the Board.

6.2 In attendance

Executive Director of Nursing and Midwifery, Therapies and Health Sciences (Lead Executive)
Executive Medical Director
Chief Operating Officer Executive Director of Public Health
Director of Corporate Services
Director of Quality Assurance

6.2.1 Other Directors/Officers will attend as required by the Committee Chair, as well any others from within or outside the organisation who the Committee considers should attend, taking into account the matters under consideration at each meeting.

6.3 Member Appointments

6.3.1 The membership of the Committee shall be determined by the Chairman of the Board taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government. This includes the appointment of the Chair and Vice-Chair of the Committee who shall be Independent Members.

6.3.2 Appointed Independent Members shall hold office on the Committee for a period of up to 4 years. Tenure of appointments will be staggered to ensure business

continuity. A member may resign or be removed by the Chairman of the Board. Independent Members may be reappointed up to a maximum period of 8 years.

6.4 Secretariat

6.4.1 Secretary: as determined by the Board Secretary.

6.5 Support to Committee Members

6.5.1 The Board Secretary, on behalf of the Committee Chair, shall:

- Arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role; and
- Ensure the provision of a programme of development for Committee members as part of the overall Board Development programme.

7. COMMITTEE MEETINGS

7.1 Quorum

7.1.1 At least two Independent Members must be present to ensure the quorum of the Committee, one of whom should be the Committee Chair or Vice-Chair. In the interests of effective governance, it is expected that a minimum of two Executive Directors will also be in attendance.

7.2 Frequency of Meetings

7.2.1 Meetings shall be routinely be held on a monthly basis.

7.3 Withdrawal of individuals in attendance

7.3.1 The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

8. RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

8.1 Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall

responsibility and accountability for ensuring the quality and safety of healthcare for its citizens through the effective governance of the organisation.

8.2 The Committee is directly accountable to the Board for its performance in exercising the functions set out in these Terms of Reference,

8.3 The Committee, through its Chair and members, shall work closely with the Board's other Committees including joint committees/Advisory Groups to provide advice and assurance to the Board through the:

8.3.1 joint planning and co-ordination of Board and Committee business; and

8.3.2 sharing of information

in doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance arrangements.

8.4 The Committee shall embed the corporate goals and priorities through the conduct of its business.

9. REPORTING AND ASSURANCE ARRANGEMENTS

9.1 The Committee Chair shall:

9.1.1 report formally, regularly and on a timely basis to the Board on the Committee's activities via the Chair's assurance report as well as the presentation of an annual report;

9.1.2 ensure appropriate escalation arrangements are in place to alert the Health Board Chair, Chief Executive or Chairs of other relevant committees of any urgent/critical matters that may affect the operation and/or reputation of the Health Board.

9.2 The Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation. In doing so account will be taken of the requirements set out in the NHS Wales Quality and Safety Committee Handbook.

10. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

10.1 The requirements for the conduct of business as set out in the Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum

11. REVIEW

11.1 These terms of reference and operating arrangements shall be reviewed annually by the Committee and any changes recommended to the Board for approval.

Date of approval by the Board:- ……

...

Betsi Cadwaladr University Health Board
Terms of Reference and Operating Arrangements

FINANCE AND PERFORMANCE COMMITTEE

1. INTRODUCTION

1.1 The Board shall establish a committee to be known as Finance and Performance Committee (F&P). The detailed terms of reference and operating arrangements in respect of this Committee are set out below.

2. PURPOSE

2.1 The purpose of the Committee is to advise and assure the Board in discharging its responsibilities with regard to its current and forecast financial position and performance and delivery. This includes the Board's Capital Programme, Informatics and Information Governance, Communications and Technology Programmes and Workforce matters.

3. DELEGATED POWERS

3.1 The Committee, in respect of its provision of advice and assurance will, and is authorised by the Board to: -

3.1.1 Financial Management

- seek assurance on the Financial Planning process and consider Financial Plan proposals
- monitoring financial performance and cash management against revenue budgets and statutory duties;
- consider submissions to be made in respect of revenue or capital funding and the service implications of such changes including screening and review of financial aspects of business cases as appropriate for submission to Board in line with Standing Financial *Instructions;*
- Review on an annual basis the Board's Standing Financial Instructions and Scheme of Financial Delegation.
- receive assurance with regard to the progress and impact/pace of implementation of organisational savings plans.
- receive quarterly assurance reports arising from performance reviews, including performance and accountability reviews of individual teams.

3.1.2. Performance Management and accountability

- approve the Health Board's overall Performance Management Framework
- ensure detailed scrutiny of the performance and resources dimensions of the Integrated Quality and Performance Report (IQPFR);
- monitor performance and quality outcomes against Welsh Government targets including access times, efficiency measures and other performance improvement indicators, including local targets;
- review in year progress in implementing the financial aspects of the Integrated Medium Term Plan (IMTP);;
- review and monitor performance against external contracts
- receive assurance reports arising from Performance and Accountability Reviews of individual teams.

3.1.3 Capital Expenditure and Working Capital

- approve and monitor progress of the Capital Programme.

3.1.4 Informatics and Information Governance

- approve and monitor progress of the Informatics Operational plan including performance against the annual Informatics Capital Programme;
- monitor performance and delivery of the rollout of the core national IT systems, in particular
    - Patient Administration
    - Emergency Department
    - Community Care Information Systems
    - Welsh Clinical Portal

- To review other major IT systems developments which could have significant impact on the Health Boards operational services to monitor performance including access timeframes, efficiency measures and other performance improvement measures, including local targets.
- To provide assurance that the Health Board is discharging its functions and meeting its responsibilities with regard to Information Governance, including Caldicott and Health Care Records;

3.1.5 Workforce

- Monitor performance against key workforce indicators as part of the IQPR;
- Monitor the financial aspects of workforce planning to meet service needs in line with agreed strategic plans.

- Receive quarterly assurance reports in relation to workforce, to include job planning under Medical and Dental contracts for Consultants and Specialist and Associate Specialist (SAS) doctors and the application of rota management for junior doctors, including the revalidation processes for medical and dental staff and registered nurses, midwifes and health visitors and Allied professionals

4. AUTHORITY

4.1 The Committee may investigate or have investigated any activity (clinical and non-clinical) within its terms of reference. It may seek relevant information from any:

- employee (and all employees are directed to cooperate with any legitimate request made by the Committee); and
- other committee, sub committee or group set up by the Board to assist it in the delivery of its functions.

4.2 May obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements;

4.3 May consider and where appropriate, approve on behalf of the Board any policy within the remit of the Committee's business;

4.4 Will review risks from the Corporate Risk Register that are assigned to the Committee by the Board and advise the Board on the appropriateness of the scoring and mitigating actions in place.

5. SUB-COMMITTEES

5.1 The Committee may, subject to the approval of the Health Board, establish sub-committees or task and finish groups carry out on its behalf specific aspects of Committee business.

6. MEMBERSHIP

6.1 Members

Four Independent Members of the Board

6.2 In attendance

Executive Director of Finance (Lead Director)
Chief Operating Officer
Executive Director of Workforce and Organisational Development
Executive Director of Strategy

6.2.1 Other Directors/Officers will attend as required by the Committee Chair, as well any others from within or outside the organisation who the Committee considers should attend, taking into account the matters under consideration at each meeting.

6.3 Member Appointments

6.3.1 The membership of the Committee shall be determined by the Chairman of the Board taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government. This includes the appointment of the Chair and Vice-Chair of the Committee who shall be Independent Members.

6.3.2 Appointed Independent Members shall hold office on the Committee for a period of up to 4 years. Tenure of appointments will be staggered to ensure business continuity. A member may resign or be removed by the Chairman of the Board. Independent Members may be reappointed up to a maximum period of 8 years.

6.4 Secretariat

6.4.1 Secretary: as determined by the Board Secretary.

6.5 Support to Committee Members

6.5.1 The Board Secretary, on behalf of the Committee Chair, shall:

- Arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role; and
- Ensure the provision of a programme of development for Committee members as part of the overall Board Development programme.

7. COMMITTEE MEETINGS

7.1 Quorum

7.1.1 At least two Independent Members must be present to ensure the quorum of the Committee, this should include either the Chair or the Vice-Chair of the Committee. In the interests of effective governance it is expected that a minimum of two Executive Directors will also be in attendance.

7.2 Frequency of Meetings

7.2.1 Meetings shall be routinely be held on a monthly basis.

7.3 Withdrawal of individuals in attendance

7.3.1 The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

8. RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

8.1 Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for ensuring the quality and safety of healthcare for its citizens through the effective governance of the organisation.

8.2 The Committee is directly accountable to the Board for its performance in exercising the functions set out in these Terms of Reference,

8.3 The Committee, through its Chair and members, shall work closely with the Board's other Committees including joint committees/Advisory Groups to provide advice and assurance to the Board through the:

8.3.1 joint planning and co-ordination of Board and Committee business; and

8.3.2 sharing of information

in doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance arrangements.

8.4 The Committee shall embed the corporate goals and priorities through the conduct of its business.

9. REPORTING AND ASSURANCE ARRANGEMENTS

9.1 The Committee Chair shall:

9.1.1 report formally, regularly and on a timely basis to the Board on the Committee's activities via the Chair's assurance report as well as the presentation of an annual report;

9.1.2 ensure appropriate escalation arrangements are in place to alert the

Health Board Chair, Chief Executive or Chairs of other relevant committees of any urgent/critical matters that may affect the operation and/or reputation of the Health Board.

9.2 The Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation.

10. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

10.1 The requirements for the conduct of business as set out in the Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum

11. REVIEW

11.1 These terms of reference and operating arrangements shall be reviewed annually by the Committee and any changes recommended to the Board for approval.

Date of approval by the Board:-

……

Betsi Cadwaladr University Health Board
Terms of Reference and Operating Arrangements

STRATEGY, PARTNERSHIPS AND POPULATION HEALTH COMMITTEE

1. INTRODUCTION

1.1 The Board shall establish a committee to be known as the Strategy, Partnerships and Population Health Committee (SP&PH). The detailed terms of reference and operating arrangements set by the Board in respect of this Committee are set out below.

2. PURPOSE

2.1 The purpose of the Committee is to provide advice and assurance to the Board with regard to the development of the Health Board's strategies and plans for the delivery of high quality and safe services, consistent with the Board's overall strategic direction and any requirements and standards set for NHS bodies in Wales. The Committee will do this by ensuring that strategic collaboration and effective partnership arrangements are in place to improve population health and reduce health inequalities.

3. DELEGATED POWERS

3.1 The Committee, in respect of its provision of advice and assurance will and is authorised by the Board to:-

3.1.1 ensure that current and emerging service strategies adhere to national policy and legislation , the priorities of the Health Board and are underpinned by robust population health needs assessment, workforce and financial plans and provide for sustainable futures;

3.1.2 advise and assure the Board in discharging its responsibilities with regard to the development of the Health Board's Medium and long term plans, together with the Annual Operating Plan;

3.1.3 ensure the Health Board's response to new and revised legislative requirements in relation to service planning and delivery, providing assurance that statutory duties will be appropriately discharged, ensuring strategic alignment between partnership plans developed with Local Authorities, Universities, third sector and other public sector organisations;

3.1.4 ensure that the Health Board meets its duties in relation to prison health, Welsh language, civil contingencies legislation and emergency preparedness;

3.1.5 ensure the alignment of supporting strategies such as Workforce, Capital Planning, Estates infrastructure and Information, Communications and Technology (ICT) in the development of the Strategic Plans;

3.1.6 ensure that the partnership governance arrangements reflect the principles of good governance with the appropriate level of delegated authority and support to discharge their responsibilities; and

3.1.7 ensure appropriate arrangements for continuous engagement are in place;

4. AUTHORITY

4.1 The Committee may investigate or have investigated any activity (clinical and non-clinical) within its terms of reference. It may seek relevant information from any:

- employee (and all employees are directed to cooperate with any legitimate request made by the Committee); and
- other committees, sub-committee or group set up by the Board to assist it in the delivery of its functions.

4.2 It may obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements;

4.3 It may consider and where appropriate, approve on behalf of the Board any policy within the remit of the Committee's business concerning Strategy, Partnerships and Population Health matters.

4.4 It will review risks from the Corporate Risk Register that are assigned to the Committee by the Board and advise the Board on the appropriateness of the scoring and mitigating actions in place.

5. SUB-COMMITTEES

5.1 The Committee may, subject to the approval of the Health Board, establish sub-committees or task and finish groups to carry out on its behalf specific aspects of Committee business.

6. MEMBERSHIP

6.1 Members

Four independent members of the Board

6.2 In attendance

Executive Director of Strategy (Lead Director)
Executive Director of Public Health
Executive Director of Workforce and Organisational Development

6.2.1 Other Directors/Officers will attend as required by the Committee Chair, as well any others from within or outside the organisation who the Committee considers should attend, taking into account the matters under consideration at each meeting.

6.3 Member Appointments

6.3.1 The membership of the Committee shall be determined by the Chairman of the Board taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government. This includes the appointment of the Chair and Vice-Chair of the Committee who shall be Independent Members.

6.3.2 Appointed Independent Members shall hold office on the Committee for a period of up to 4 years. Tenure of appointments will be staggered to ensure business continuity. A member may resign or be removed by the Chairman of the Board. Independent Members may be reappointed up to a maximum period of 8 years.

6.4 Secretariat

6.4.1 Secretary: as determined by the Board Secretary.

6.5 Support to Committee Members

6.5.1 The Board Secretary, on behalf of the Committee Chair, shall:

- Arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role; and

- Ensure the provision of a programme of development for Committee members as part of the overall Board Development programme.

7. COMMITTEE MEETINGS

7.1 Quorum

7.1.1 At least two Independent Members must be present to ensure the quorum of the Committee, one of whom should be the Committee Chair or Vice-Chair. In the interests of effective governance it is expected that a minimum of one Executive Director will also be in attendance.

7.2 Frequency of Meetings

7.2.1 Meetings shall be routinely be held on a bi-monthly basis.

7.3 Withdrawal of individuals in attendance

6.3.1 The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

8. RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

8.1 Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for ensuring the quality and safety of healthcare for its citizens through the effective governance of the organisation.

8.2 The Committee is directly accountable to the Board for its performance in exercising the functions set out in these Terms of Reference,

8.3 The Committee, through its Chair and members, shall work closely with the Board's other Committees including joint committees/Advisory Groups to provide advice and assurance to the Board through the:

8.3.1 joint planning and co-ordination of Board and Committee business; and

8.3.2 sharing of information

in doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance arrangements.

8.4 The Committee shall embed the corporate goals and priorities through the conduct of its business.

9. REPORTING AND ASSURANCE ARRANGEMENTS

9.1 The Committee Chair shall:

9.1.1 report formally, regularly and on a timely basis to the Board on the Committee's activities via the Chair's assurance report as well as the presentation of an annual report;

9.1.2 ensure appropriate escalation arrangements are in place to alert the Health Board Chair, Chief Executive or Chairs of other relevant committees of any urgent/critical matters that may affect the operation and/or reputation of the Health Board.

9.2 The Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation.

10. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

10.1 The requirements for the conduct of business as set out in the Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum

11. REVIEW

11.1 These terms of reference and operating arrangements shall be reviewed annually by the Committee and any changes recommended to the Board for approval.

Date of approval by the Board:- ……

Betsi Cadwaladr University Health Board
Terms of Reference and Operating Arrangements

MENTAL HEALTH ACT COMMITTEE

1. INTRODUCTION

1.1 The Board shall establish a committee to be known as the **Mental Health Act Committee**. The detailed terms of reference and operating arrangements in respect of this Committee are set out below. Background information in relation to the Mental Health Act, the Mental Health Measure and the Mental Capacity Act is set out in Annex 1. The Committee will also consider, when appropriate, any other legislation that impacts on mental health and mental capacity. It will regularly report to the Board and advise it of any areas of concern.

2. PURPOSE

2.1 The purpose of the Committee is to consider and monitor the use of the Mental Health Act 1983 (MHA), Mental Capacity Act 2005 (which includes the Deprivation of Liberty Safeguards (DoLS) (MCA) and the Mental Health (Wales) Measure 2010 (the Measure) and give assurance to the Board that:

- Hospital Managers' duties under the Mental Health Act 1983;
- the functions and processes of discharge under section 23 of the Act;
- the provisions set out in the Mental Capacity Act 2005, and
- in the Mental Health Measure (Wales) 2010

are all exercised in accordance with statute and that there is compliance with:

- the Mental Health Act 1983 Code of Practice for Wales
- the Mental Capacity Act 2005 Code of Practice
- the Mental Capacity Act 2005 Deprivation of Liberty Safeguards Code of Practice
- the Human Rights Act 1998
- the United Nations Convention on the Rights of People with Disabilities
- the associated Regulations and local Policies

3. DELEGATED POWERS AND AUTHORITY

3.1 The Committee, in respect of its provision of advice and assurance will and is authorised by the Board to: -

- ensure that those acting on behalf of the Board in relation to the provisions of Mental Health and Capacity legislation, including the Measure, have the requisite skills and competencies to discharge the Board's responsibilities;
- identify matters of risk relating to Mental Health and Capacity legislation and seek assurance that such risks are being mitigated;
- monitor the use of the legislation and consider local trends and benchmarks;

- consider matters arising from the Hospital Managers' Power of Discharge Sub-Committee;
- ensure that **all** other relevant associated legislation is considered in relation to Mental Health and Capacity legislation;
- consider matters arising from visits undertaken by Healthcare Inspectorate Wales Review* Service for Mental Health in particular, issues relating to Mental Health Act 1983 and monitor action plans that inform responses to HIW reports;
- consider any reports made by the Public Services Ombudsman for Wales regarding complaints about Mental Health and Capacity legislation;
- receive and review reports on the approval for all Wales Approved Clinicians and Section 12(2) Doctors;
- consider and approve on behalf of the Board any LHB policy which relates to the implementation of mental health and capacity legislation as well as any other information, reports etc. that the Committee deems appropriate;
- receive and review DoLS reports regarding authorisations and associated reasons;
- receive and review reports on the implementation of the Mental Health Measure and be satisfied that positive outcomes for people are being achieved;
- receive and review the results of internal audit reports relating to care and treatment plans, as well as any other relevant reports relating to the Mental Health Measure;
- receive the results of clinical audits and any other reviews relating to the use of the Mental Health Act and oversee the implementation of recommendations;
- consider any other information, reports, etc. that the Committee deems appropriate.
- investigate or have investigated any activity (clinical and non-clinical) within its terms of reference. It may seek relevant information from any:

    - employee (and all employees are directed to cooperate with any legitimate request made by the Committee); and

    - other committee, sub-committee or group set up by the Board to assist it in the delivery of its functions.

- obtain outside legal or other independent professional advice and to secure the attendance of non members with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements;

*Note – HIW report recommendations are the remit of Quality Safety and Experience Committee (QSE) however any specific recommendations relating to Mental Health or the Mental Capacity Act will be the remit of this Committee who will respond as appropriate ensuring the Board and QSE are appraised accordingly.

Sub Committees/Panels

3.2 The Committee may, subject to the approval of the Health Board, establish Sub-Committees or task and finish groups to carry out on its behalf specific aspects of Committee business.

3.3 Sub-Committee - In accordance with Regulation 12 of the Local Health Boards (Constitution, Procedure and Membership) (Wales) Regulations 2003 (SI 2003/149 (W.19), the Board has appointed a Sub-Committee of this Committee, to be known as the Power of Discharge Sub-Committee, terms of reference for which are attached as Annex 2.

3.4 Panel - Three members drawn from the pool of designated Associate Hospital Managers will constitute a panel to consider the possible discharge or continued detention under the MHA of unrestricted patients and those subject to Supervised Community Treatment Order (SCT).

3.5 The Board retains final responsibility for the performance of the Hospital Managers' duties delegated to particular people on the staff of Betsi Cadwaladr University Local Health Board, as well as the Power of Discharge Sub-Committee.

4. MEMBERSHIP

4.1 Members

Four Independent Members of the Board to include one who is a Member of the Quality, Safety and Experience Committee and one who shall be the Chair of the Power of Discharge Sub-Committee.

4.2 In attendance

Chief Operating Officer (with responsibility for Primary Care and Community and Mental Health Services)
Executive Director of Nursing and Midwifery
Medical Director for Mental Health
Nursing Director for Mental Health
Mental Health Director
Mental Health Act Manager
Service User Representative
Carer Representative
Social Services Representative
North Wales Police Representative
Welsh Ambulance Services NHS Trust Representative
IMCA Advocacy provider Representative
IMHA Advocacy provider Representative
MCA representative
DoLS representative
Two Associate Hospital Managers (as nominated by the Power of Discharge Sub-Committee)

4.3 Other Directors will attend as required by the Committee Chair, as well any others from within or outside the organisation who the Committee considers should attend, taking into account the matters under consideration at each meeting.

4.4 Member Appointments

4.4.1 The membership of the Committee shall be determined by the Board, based on the recommendation of the Health Board Chair - taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government. This includes the appointment of the Chair and Vice-Chair of the Committee who shall be Independent Members. The Vice-Chair of the Health Board will be the Chair of this Committee and shall retain the role of Chair of this Committee throughout their tenure of appointment.

4.4.2 Other appointed Independent Members shall hold office on the Committee for a period of up to 4 years. Tenure of appointments will be staggered to ensure business continuity. A member may resign or be removed from the Committee by the Board. Independent Members may be reappointed up to a maximum period of 8 years.

4.5 Secretariat

4.5.1 Secretary: as determined by the Board Secretary.

4.6 Support to Committee Members

4.6.1 The Board Secretary, on behalf of the Committee Chair, shall:

- Arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role; and

- Ensure the provision of a programme of development for Committee members as part of the overall Board Development programme.

5. COMMITTEE MEETINGS

5.1 Quorum

5.1.1 At least two Independent Members must be present to ensure the quorum of the Committee, one of whom should be the Committee Chair or Vice-Chair.

5.2 Frequency of Meetings

5.2.1 Meetings shall routinely be held on a quarterly basis.

5.3 Withdrawal of individuals in attendance

5.3.1 The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

6. RELATIONSHIP AND ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES

6.1 Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for ensuring the quality and safety of healthcare for its citizens through the effective governance of the organisation.

6.2 The Committee is directly accountable to the Board for its performance in exercising the functions set out in these Terms of Reference.

6.3 The Committee, through its Chair and members, shall work closely with the Board's other Committees to provide advice and assurance to the Board through the:

6.3.1 joint planning and co-ordination of Board and Committee business; and

6.3.2 sharing of information

in doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance arrangements.

6.4 The Committee shall embed the corporate goals and priorities through the conduct of its business.

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

7.1.1 report formally, regularly and on a timely basis to the Board on the Committee's activities, via the Chair's assurance report as well as the presentation of an annual Committee report;

7.1.2 ensure appropriate escalation arrangements are in place to alert the Health Board Chair, Chief Executive or Chairs' of other relevant committees of any urgent/critical matters that may affect the operation and/or reputation of the Health Board.

7.2 The Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation.

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

8.1 The requirements for the conduct of business as set out in the Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum

9. REVIEW

9.1 These terms of reference and operating arrangements shall be reviewed annually by the Committee and any changes recommended to the Board for approval.

Date of approval by the Board: ……..

Annex 1

BACKGROUND INFORMATION REGARDING THE ASSOCIATED LEGISLATION

Mental Health Act 1983 (as amended by the Mental Health Act 2007)

The Mental Health Act 1983 covers the legal framework to allow the care and treatment of mentally disordered persons to be detained if deemed to be a risk to themselves or others. It also provides the legislation by which people suffering from a mental disorder can be detained in hospital to have their disorder assessed or treated against their wishes.

The MHA introduced the concept of “Hospital Managers” which for hospitals managed by a Local Health Board are the Board Members. The term “Hospital Managers” does not occur in any other legislation.

Hospital Managers have a central role in operating the provisions of the MHA; specifically, they have the authority to detain patients admitted and transferred under the MHA. For those patients who become subject to Supervised Community Treatment (SCT), the Hospital Managers are those of the hospital where the patient was detained immediately before going on to SCT - i.e. the responsible hospital or the hospital to which responsibility has subsequently been assigned.

Hospital Managers must ensure that patients are detained only as the MHA allows, that their treatment and care is fully compliant with the MHA and that patients are fully informed of and supported in exercising their statutory rights. Hospital Managers must also ensure that a patient’s case is dealt with in line with associated legislation.

With the exception of the power of discharge, arrangements for authorising day to day decisions made on behalf of Hospital Managers have been set out in the Health Board’s Scheme of Delegation.

Mental Health Measure

The Mental Health (Wales) Measure received Royal Assent in December 2010 and is concerned with:

- providing mental health services at an earlier stage for individuals who are experiencing mental health problems to reduce the risk of further decline in mental health;
- making provision for care and treatment plans for those in secondary mental health care and ensure those previously discharged from secondary mental health services have access to those services when they believe their mental health may be deteriorating;
- extending mental health advocacy provision.

Mental Capacity Act

The MCA came into force mainly in October 2007. It was amended by the Mental Health Act 2007 to include the Deprivation of Liberty Safeguards (DoLS). DoLS came into force in April 2009.

The MCA covers three main issues:

- The process to be followed where there is doubt about a person's decision-making abilities and decisions therefore where 'Best Interest' may need to be made on their behalf (e.g. about treatment and care)
- How people can make plans and/or appoint other people to make decisions for them at a time in the future when they can't take their own decisions
- The legal framework for caring for adult, mentally disordered, incapacitated people in situations where they are deprived of their liberty in hospitals or care homes (DoLS) and/or where Court of Protection judgements are required.

Thus the scope of MCA extends beyond those patients who have a mental disorder.

Annex 2

POWER OF DISCHARGE SUB-COMMITTEE
TERMS OF REFERENCE AND OPERATING ARRANGEMENTS

1. INTRODUCTION

1.1 The Board shall establish a sub-committee to be known as the Power of Discharge Sub-Committee. The detailed terms of reference and operating arrangements in respect of this Sub-Committee are set out below.

2. PURPOSE

2.1 The purpose of the Power of Discharge Sub-Committee (hereafter, the Sub-Committee) is to advise and assure the Board that the processes associated with the discharge of patients from compulsory powers that are used by the Sub-Committee are being performed correctly and in accordance with legal requirements.

3. DELEGATED POWERS AND AUTHORITY

3.1 The Sub-Committee, in respect of its provision of advice and assurance will and is authorised by the Board to:-

- Comment specifically upon the processes employed by the Sub-Committee's Panel in relation to the discharge of patients from compulsory powers, and whether these processes are fair, reasonable and compliant with the Mental Health Act and are in line with other related legislation, including, the Mental Capacity Act 2005, the Human Rights Act 1998 and the Data protection Act 1998 and that the appropriate systems are in place to ensure the effective scrutiny of associated discharge documentation.

- undertake the functions of Section 23 of the Mental Health Act 1983, in relation to hearing cases of detained powers ensuring that three or more members of the Sub-Committee form a Panel and only a minimum of three members in agreement may exercise the power of discharge. The Panel will be drawn from the pool of members formally designated as Hospital Manager as reported to the Sub-Committee.

- investigate or have investigated any activity (clinical and non-clinical) within its terms of reference. It may seek relevant information from any:

    - employee (and all employees are directed to cooperate with any legitimate request made by the Committee); and

    - other committee, sub-committee or group set up by the Board to assist it in the delivery of its functions.

- obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements;

3.2 The Sub-Committee will, as part of its process of hearing cases, be made aware of operational issues affecting the patient's care and treatment, including discharge arrangements. These are not matters for which the Sub-Committee shall have responsibility. Even so, Sub-Committee members are not precluded from raising such matters with those holding operational responsibility. In addition, such issues can be raised on an anonymised basis or through the Board itself.

4. MEMBERSHIP

Members

4.1 Three Independent Members of the Board.
A maximum of ten (10) appointed MHA Managers (as nominated and agreed by the Sub-Committee)

Attendees

Director of Mental Health
Senior Mental Health Clinicians
Mental Health Act Manager
Officer Representatives for Learning Disabilities and Children's Services

4.2. Other Directors will attend as required by the Committee Chair, as well any others from within or outside the organisation who the Committee considers should attend, taking into account the matters under consideration at each meeting.

Secretariat

4.3 Secretary As determined by the Board Secretary

4.4 Member Appointments

4.4.1 The membership of the Committee shall be determined by the Board, based on the recommendation of the Health Board Chair - taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government. This includes the appointment of the Chair and Vice-Chair of the Committee who shall be Independent Members. The Vice-Chair of the Board shall be the Chair of this Sub-Committee.

4.4.2 Appointed Independent Members shall hold office on the Committee for a period of up to 4 years. Tenure of appointments will be staggered to ensure business continuity. A member may resign or be removed from the Committee by the Board. Independent Members may be reappointed up to a maximum period of 8 years.

4.5 Secretariat

4.5.1 Secretary: as determined by the Board Secretary.

4.6 Support to Committee Members

4.6.1 The Board Secretary, on behalf of the Committee Chair, shall:

- Arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role; and

- Ensure the provision of a programme of development for Committee members as part of the overall Board Development programme.

5. SUB-COMMITTEE MEETINGS

Quorum

5.1 At least two Independent Members and four Associate Hospital Managers must be present to ensure the quorum of the Sub-Committee one of whom should be the Chair or Vice-Chair.

Frequency of Meetings

5.2 Meetings shall routinely be held on a quarterly basis.

Withdrawal of individuals in attendance

5.3 The Sub-Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

6. RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

6.1 Although the Board has delegated authority to the Sub-Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for ensuring the quality and safety of healthcare for its citizens through the effective governance of the organisation.

6.2 The Sub-Committee is directly accountable to the Board (via the Mental Health Act Committee) for its performance in exercising the functions set out in these Terms of Reference.

6.3 The Sub-Committee, through its Chair and members, shall work closely with the Board's other Committees to provide advice and assurance to the Board through the:

6.3.1 joint planning and co-ordination of Board and Committee business; and

6.3.2 sharing of information

in doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance arrangements.

6.4 In terms of the Board's assurance on the Mental Health Act requirements, the remit of the Sub-Committee is limited to the exercise of powers under Section 23 of the Mental Health Act 1983, rather than the wider operation, which would be the remit of the Mental Health Act Committee.

6.5 The Sub-Committee shall embed the corporate goals and priorities through the conduct of its business.

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

7.1.1 report formally, regularly and on a timely basis to the Board on the Sub-Committee's activities, via the Chair's assurance report;

7.1.2 ensure appropriate escalation arrangements are in place to alert the Health Board Chair, Chief Executive or Chairs' of other relevant committees of any urgent/critical matters that may affect the operation and/or reputation of the Health Board.

7.2 The Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Sub-Committee's performance and operation as part of the overall review of the Mental Health Act Committee.

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

8.1 The requirements for the conduct of business as set out in the Health Board's Standing Orders are equally applicable to the operation of the Sub-Committee, except in the following areas:

- Quorum
- owing to the nature of the business of the Sub-Committee, meetings will not be held in public.

9. REVIEW

9.1 These terms of reference and operating arrangements shall be reviewed annually by the Sub-Committee and any changes recommended to the Board, with reference to the Mental Health Act Committee for approval.

Date of approval by the Board: ……..

Betsi Cadwaladr University Health Board
Terms of Reference and Operating Arrangements

REMUNERATION AND TERMS OF SERVICE COMMITTEE

1. INTRODUCTION

1.1 The Board shall establish a committee to be known as the Remuneration and Terms of Service Committee **(R&TS)**. The detailed terms of reference and operating arrangements in respect of this Committee are set out below.

2. PURPOSE

2.1 The purpose of the Committee is to provide:

- advice to the Board on remuneration and terms of service for the Chief Executive, Executive Directors and other senior staff within the framework set by the Welsh Government;

- assurance to the Board in relation to the Health Board's arrangements for the remuneration and terms of service, including contractual arrangements, for *all staff*, in accordance with the requirements and standards determined for the NHS in Wales; and

- to perform certain, specific functions as delegated by the Board and listed below.

3. DELEGATED POWERS AND AUTHORITY

3.1 The Committee, in respect of its provision of advice and assurance will and is authorised by the Board to: -

3.1.1 comment specifically upon

- the remuneration and terms of service for the Chief Executive, Executive Directors and other Very Senior Managers (VSMs) not covered by Agenda for Change; ensuring that the policies on remuneration and terms of service as determined from time to time by the Welsh Government are applied consistently;
- objectives for Executive Directors and other VSMs and their performance assessment;
- performance management system in place for those in the positions mentioned above and its application;
- proposals to make additional payments to consultants;
- proposals regarding termination arrangements, ensuring the proper calculation and scrutiny of termination payments in accordance with the relevant Welsh Government guidance.
- removal and relocation expenses

3.1.2 consider and approve Voluntary Early Release scheme applications and severance payments in line with Standing Orders and extant Welsh Government guidance.

3.1.3 to monitor compliance with issues of professional registration.

3.1.4 monitor and review risks from the Corporate Risk Register that are assigned to the Committee by the Board and advise the Board on the appropriateness of the scoring and mitigating actions in place;

3.1.5 investigate or have investigated any activity (clinical and non-clinical) within its terms of reference. It may seek relevant information from any:

- employee (and all employees are directed to cooperate with any legitimate request made by the Committee); and
- other committee, sub-committee or group set up by the Board to assist it in the delivery of its functions.

3.1.6 obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements;

3.1.7 consider and where appropriate, approve on behalf of the Board any policy within the remit of the Committee's business.

4. SUB-COMMITTEES

4.1 The Committee may, subject to the approval of the Health Board, establish sub-committees or task and finish groups to carry out on its behalf specific aspects of Committee business.

5. MEMBERSHIP

5.1 Members

Four Independent Members of the Board
The Chair of the Audit Committee will be appointed to this Committee either as Vice-Chair or a member.

5.2 In attendance

Chief Executive Officer
Executive Director of Workforce and Organisational Development (Lead Director)

5.2.1 Other Directors will attend as required by the Committee Chair, as well any others from within or outside the organisation who the Committee considers should attend, taking into account the matters under consideration at each meeting. A Staff side Chair of the Local Partnership Forum will be in attendance at meetings held in public as an ex-officio member.

5.3 Member Appointments

5.3.1 The membership of the Committee shall be determined by the Chairman of the Board taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government. This includes the appointment of the Chair and Vice-Chair of the Committee who shall be Independent Members.

5.3.2 Appointed Independent Members shall hold office on the Committee for a period of up to 4 years. Tenure of appointments will be staggered to ensure business continuity. A member may resign or be removed by the Chairman of the Board. Independent Members may be reappointed up to a maximum period of 8 years.

5.4 Secretariat

5.4.1 Secretary: as determined by the Board Secretary.

5.5 Support to Committee Members

5.5.1 The Board Secretary, on behalf of the Committee Chair, shall:

- Arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role; and
- Ensure the provision of a programme of development for Committee members as part of the overall Board Development programme.

6. COMMITTEE MEETINGS

6.1 Quorum

6.1.1 At least two Independent Members must be present to ensure the quorum of the Committee, one of whom should be the Committee Chair or Vice-Chair. In the interests of effective governance it is expected that at least one Executive Director will also be in attendance.

6.2 Frequency of Meetings

6.2.1 The Chair of the Committee, in agreement with Committee Members, shall determine the timing and frequency of meetings, as deemed necessary. It is expected that the Committee shall meet at least once a year, consistent with the Health Board's annual plan of Board Business.

6.3 Withdrawal of individuals in attendance

5.3.1 The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

7. RELATIONSHIP AND ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES

7.1 Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for ensuring the quality and safety of healthcare for its citizens through the effective governance of the organisation.

7.2 The Committee is directly accountable to the Board for its performance in exercising the functions set out in these Terms of Reference.

7.3 The Committee, through its Chair and members, shall work closely with the Board's other Committees to provide advice and assurance to the Board through the:

7.3.1 joint planning and co-ordination of Board and Committee business; and

7.3.2 sharing of information

in doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance arrangements.

7.4 The Committee shall embed the corporate goals and priorities through the conduct of its business.

8. REPORTING AND ASSURANCE ARRANGEMENTS

8.1 The Committee Chair shall:

8.1.1 report formally, regularly and on a timely basis to the Board on the Committee's activities, via the Chair's assurance report as well as the presentation of an annual Committee report;

8.1.2 ensure appropriate escalation arrangements are in place to alert the Health Board Chair, Chief Executive or Chairs' of other relevant committees of any urgent/critical matters that may affect the operation and/or reputation of the Health Board.

8.2 The Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation.

9. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

9.1 The requirements for the conduct of business as set out in the Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum

10. REVIEW

10.1 These terms of reference and operating arrangements shall be reviewed annually by the Committee and any changes recommended to the Board for approval.

Date of approval by the Board:-

……

Betsi Cadwaladr University Health Board
Terms of Reference and Operating Arrangements

CHARITABLE FUNDS COMMITTEE

1. INTRODUCTION

1.1 The Board shall establish a committee to be known as the **Charitable Funds Committee** ('the Committee'). The detailed terms of reference and operating arrangements set by the Board in respect of this committee are set out below.

2. PURPOSE

2.1 The purpose of the Committee is to make and monitor arrangements for the control and management of the Health Board's charitable funds. The Betsi Cadwaladr University Health Board (BCUHB) was appointed as the corporate trustee of the charitable funds by virtue of Statutory Instrument and the Board (acting as the Board of Trustees) serves as its agent in the administration of the charitable funds held by BCUHB.

3. DELEGATED POWERS & AUTHORITY

3.1 The Committee, in respect of its responsibilities to make and monitor arrangements and oversee the development of fundraising strategy and policy for the control and management of charitable funds, is authorised by the Board to:-

3.1.1 ensure the budget, priorities and spending criteria determined by the Health Board as trustee are consistent with the requirements of the Charities Act 1993, Charities Act 2006 (or any modification of these acts) when applied to charitable funds in accordance with their respective governing documents, including the "Declaration of Trust" (Trust Deed).

3.1.2 make decisions involving the sound investment of charitable funds, managing the risk of any loss in capital value alongside producing a return consistent with prudent investment in the long term and ensuring compliance with:-

- Trustee Act 2000
- The Charities Act 1993
- The Charities Act 2006
- Terms of the fund's governing documents

3.1.3 receive at least four times per year reports for ratification from the Executive Director of Finance, and to make and enact investment decisions taken through delegated powers upon the advice of the Health Board's investment adviser.

3.1.4 monitor the functions performed by the Executive Director of Finance as defined in Standing Financial Instructions.

3.1.5 respond to, and monitor the level of, donations and legacies received, including the progress of any Charitable Appeal Funds.

3.1.6 monitor and review the Health Board's scheme of delegation for Charitable Funds expenditure and to set and reflect in Financial Procedures the approved delegated limits for expenditure from Charitable Funds.

3.1.7 ensure that funds are being utilised appropriately in line with both the instructions and wishes of the donor. To ensure such funding provides added value and benefit to patients and staff, and that all expenditure is reasonable, clinically and ethically appropriate

3.1.8 ensure that the reserve policy is kept under review to ensure that balances are not inappropriately retained.

3.1.9 establish a sub-committee to be known as the Charitable Funds Advisory Group, to review specific funding applications (as detailed in the Advisory Group Guidelines and Health Board scheme of delegation) and make recommendations to the Committee for approval or rejection. The Advisory Group cannot make any decisions regarding funding applications over £5,000; its remit is only to provide advice and recommendations to the Committee and the final decision rests with the Committee.

3.1.10 ensure that there is a clear strategy and framework for decision making, agreed by the Board of Trustees, against which bids for funding can be evaluated by Fund Advisors, other Health Board staff, the Charitable Funds Advisory Group and the Committee.

3.1.11 ensure day-to-day management of the investments of the charitable funds in accordance with the investment strategy set down from time to time by the trustee and the requirements of the Health Board's Standing Financial Instructions.

3.1.12 appoint an investment manager to advise on investment matters. The Committee may delegate day-to-day management of some or all of the investments to that investment manager. In exercising this power the Committee must ensure that:

- the scope of the power delegated is clearly set out in writing and communicated with the person or persons who will exercise it;
- there are in place adequate internal controls and procedures which will ensure that the power is being exercised properly and prudently;
- the performance of the person or persons exercising the delegated power is regularly reviewed;
- where an investment manager is appointed, that the person is regulated under the Financial Services Act 1986;

- acquisitions or disposal of a material nature always have written authority of the Committee or the Chair of the Committee in conjunction with the Executive Director of Finance.
- the banking arrangements for the charitable funds are kept entirely distinct from the Health Board's NHS funds.
- separate current and deposit accounts are minimised consistent with meeting expenditure obligations.
- the amount to be invested or redeemed from the sale of investments shall have regard to the requirements for immediate and future expenditure commitments.
- there is proper operation of an investment pool when this is considered appropriate to the charity in accordance with charity law and the directions and guidance of the Charity Commission. The Committee shall propose the basis to the Health Board for applying accrued income to individual funds in line with charity law and Charity Commissioner guidance.
- appropriate professional advice is obtained to support its investment activities.
- investments are regularly reviewed to determine whether if other opportunities or investment managers offer a better return.

3.1.13 investigate or have investigated any activity (clinical and non-clinical) within its terms of reference. It may seek relevant information from any:

- employee (and all employees are directed to cooperate with any legitimate request made by the Committee); and
- other committee, sub-committee or group set up by the Board to assist it in the delivery of its functions.

3.1.14 obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements.

3.1.15 consider and where appropriate, approve on behalf of the Board any policy within the remit of the Committee's business concerning charitable funds matters.

3.2 Specific delegated duties of the Executive Director of Finance in respect of charitable funds include

- administration of all existing charitable funds;
- identifying any new charity that may be created (of which the Health Board is trustee) and to deal with any legal steps that may be required to formalise the trusts of any such charity;
- providing guidelines with respect to donations, legacies and bequests, fundraising and trading income;
- responsibility for the management of investment of funds held on Trust;
- ensuring appropriate banking services are available to the Health Board
- preparing reports to the Board including the Annual Accounts and Annual Report;

- monitoring the balance of monies held within the Fund
- ensuring that all expenditure (where appropriate) is ordered through the procurement process.

4. SUB-COMMITTEES

4.1 The Committee may, subject to the approval of the Health Board, establish sub-committees or task and finish groups to carry out on its behalf specific aspects of Committee business.

5. MEMBERSHIP

5.1 Members

Four (4) Independent Members of the Board
Executive Director of Finance (Lead Director)
Chief Executive Officer
Executive Director of Strategy

5.2 In attendance

5.2.1 Other Directors and officer e.g. Fundraising Manager, will attend as required by the Committee Chair, as well any others from within or outside the organisation who the Committee considers should attend, taking into account the matters under consideration at each meeting.

5.3 Member Appointments

5.3.1 The membership of the Committee shall be determined by the Chairman of the Health Board taking account of the views of Trustees, on the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government.

5.3.2 Appointed Independent Members shall hold office on the Committee for a period of up to 4 years. Tenure of appointments will be staggered to ensure business continuity. A member may resign or be removed from the Committee by the Chairman of the Health Board. Independent Members may be reappointed up to a maximum period of 8 years.

5.3.3 In order to demonstrate that that there is a visible independence in the consideration of decisions and management of charitable funds from the LHB's core functions, the Board of Trustees may consider extending membership to the Charitable Funds Committee to individuals outside of the Board.

5.4 Secretariat

Secretary: as determined by the Board Secretary.

5.5 Support to Committee Members

5.5.1 The Board Secretary, on behalf of the Committee Chair, shall:

- arrange the provision of advice and support to committee members on any aspect related to the conduct of their role; and

- ensure the provision of a programme of development for Committee members as part of the overall Board Development programme.

6. COMMITTEE MEETINGS

6.1 Quorum

6.1.1 At least three members must be present to ensure the quorum of the Committee, one of whom should be the committee Chair or Vice-Chair and one Executive Director.

6.2 Frequency of Meetings

6.2.1 Meetings shall routinely be held quarterly.

6.3 Withdrawal of individuals in attendance

6.3.1 The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

7. RELATIONSHIP AND ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES

7.1 Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for ensuring the quality and safety of healthcare for its citizens through the effective governance of the organisation.

7.2 The Committee is directly accountable to the Board for its performance in exercising the functions set out in these Terms of Reference.

7.3 The Committee, through its Chair and members, shall work closely with the Board's other Committees to provide advice and assurance to the Board through the:

7.3.1 joint planning and co-ordination of Board and Committee business; and
7.3.2 sharing of information

in doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance arrangements.

7.4 The Committee shall embed the corporate goals and priorities through the conduct of its business.

8. REPORTING AND ASSURANCE ARRANGEMENTS

8.1 The Committee Chair shall:

- report formally, regularly and on a timely basis to the Board of Trustees on the Committee's activities via the Chair's assurance report, as well as the presentation of an annual Committee report;
- ensure appropriate escalation arrangements are in place to alert the Health Board, Chief Executive or Chairs of other relevant committees of any urgent/critical matters that may affect the operation and/or reputation of the Health Board.

8.2 The Board Secretary, on behalf of the Board of Trustees, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation.

9. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

9.1 Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum

10. REVIEW

10.1 These terms of reference and operating arrangements shall be reviewed annually by the Committee and any changes recommended to the Board for approval.

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Date of approval by the Board: ……

Betsi Cadwaladr University Health Board
Terms of Reference

CHARITABLE FUNDS ADVISORY GROUP

4. INTRODUCTION

1.1 The Charitable Funds Committee (the 'Committee') has established the Charitable Funds Advisory Group which is to consider funding applications from £5,000 to £25,000 from general or specific charitable funds and approve or reject those applications. The decision to approve or reject an application is undertaken on behalf of the Charitable Funds Committee under the Charitable Funds Scheme of Delegation.

1.2 The Health Board scheme of delegation sets out the rules for approval for all levels of funding applications, including applications over £25,000 which must be approved by the Charitable Funds Committee, including the Executive Director of Finance.

5. DUTIES OF THE CHARITABLE FUNDS ADVISORY GROUP

2.1 The Charitable Funds Advisory Group reviews funding applications from £5,000 to £25,000 following the charity strategy and guidelines given by the Charitable Funds Committee, and approves or rejects applications.

6. AUTHORITY

3.1 The Advisory Group has authority to approve funding applications under the Charitable Funds Committee Scheme of Delegation.

3.2 The Advisory Group is authorised by the Charitable Funds Committee to investigate or have investigated any activity (clinical and non-clinical) within its terms of reference. It may seek relevant information from any Employee (and all employees are directed to cooperate with any legitimate request made by the Advisory Group)

4. MEMBERSHIP

4.1 Members

A panel of 8 members including the following

- The Head of Financial Services (Chair)
- An Area Director (Vice-Chair)
- 3 Ward or Clinical Managers, one each from West, Centre and East; one to be from Cancer and one to be from Public Health
- One Patient representative
- One Voluntary Services representative

Members

- Geographical spread of members should be such that there are at least 2 members each from the West, the Centre and the East

Chair/ Vice Chair

- The Chair (or Vice Chair) will prepare a report for each Charitable Funds meeting detailing the funding applications reviewed by the Advisory Group, the recommendation to approve or deny funding for each and the reason for the recommendation.
- The Chair (or Vice-Chair) will attend each Charitable Fund Committee meeting to provide further information on the applications if required

Secretary

- As determined by the Operational Director of Finance

4.2 In attendance

4.2.1 The Advisory Group may require the attendance for advice, support and information routinely at meetings from :

- Charitable Funds Accountant
- Fundraising Manager
- Appropriate clinical or other staff

4.3 Membership

4.3.1 The membership of the Advisory Group shall be determined by the Charitable Funds Committee, based on the recommendation of the Committee Chair, taking account of the balance of skills and expertise necessary.

4.3.2 Group Members shall hold office on the Advisory Group for a minimum period of a year

5 ADVISORY GROUP MEETINGS

5.1 Quorum

At least 5 members must be present to ensure the quorum of the Advisory Group, one of whom should be the Chair or Vice-Chair.

5.2 Frequency of Meetings

Meetings shall be held bi monthly and otherwise as the Advisory Group Chair deems necessary.

6 REVIEW

6.1 These terms of reference shall be reviewed annually by the Charitable Funds Committee and any changes recommended to the Health Board for approval.

Date of approval by the Board:

Committee Business Management Group
Terms of Reference

1. PURPOSE

The Group is established to oversee effective communication between Committees, avoiding duplication and ensuring all appropriate business is managed effectively and efficiently through the Health Board's Governance framework ensuring that the governance system meets statutory requirements and takes account of emerging best practice as appropriate. Specifically this will include:-

- Co-ordinating agenda setting and cycles of business
- Taking account of interdependencies and avoiding duplication or omission
- Sharing best practice
- Ensuring workforce issues and information governance matters are considered by the appropriate Committee.

The intention is that this Group will replace the individual Chair's agenda setting meetings.

2. FUNCTIONS

- To oversee, manage and agree the agenda for Finance and Performance; Quality, Safety and Experience and Strategy, Partnerships and Population Health Committees, collectively signing off the outline agenda on a rolling basis, three months in advance of the respective Committee meetings.
- To ensure that the business of the three Committees is co-ordinated to avoid both duplication and 'orphan' items.
- To ensure that the Committees' agenda properly and fully incorporate workforce issues and those of information governance.
- To oversee a programme of regular review and evaluation of Board and Committee performance incorporating a range of methods including self-assessment, independent facilitation etc. making recommendations to the Board as appropriate.
- To review the annual calendar of Board and Committee meetings for the core governance structure prior to presentation to the Board.

3. REPORTING ARRANGEMENTS

- Action notes reported back to the next meeting of the Group.

- Provide appropriate feedback to the Board and its Committees via the respective Chairs of each Committee, together with the Executive Leads and Board Secretary/Assistant Board Secretary.

4. MEMBERSHIP

Members

- Health Board Chairman (Chair of the Group)
- Chair of Audit Committee (Vice-Chair of the Group)
- Chair of Finance and Performance Committee
- Chair of the Strategy, Partnerships and Population Health Committee
- Chair of Quality, Safety and Experience Committee Director Lead for Audit; Finance and Performance; Quality, Safety and Experience; and Strategy, Partnerships and Population Health Committees.
- Assistant Board Secretary

5. MEETINGS

Quorum

The quorum for the Group shall be four members, with at least one representative i.e. Independent Member or Director representing each Committee.

Frequency of Meetings

Meetings to be held no less than quarterly (but with monthly meetings during the first three months of the Group's inception).

APPENDIX 7

Betsi Cadwaladr University Local Health Board

GMS/GDS/PDS Contracts Appeals Panel

TERMS OF REFERENCE

1. Purpose

The purpose of the GMS/GDS/PDS Contracts Appeals Panel is to consider appeals from GMS and GDS/PDS contractors against decisions of the Primary Care Panel relating to individual contractual matters.

This is the final stage of the internal appeals process to ensure that all reasonable steps to resolve disputes at local level have been taken. The next stage of the appeals process is the contractor's right to appeal to Welsh Government under the regulatory NHS Dispute Resolution Procedure.

2. Responsibilities

The Panel's responsibilities will be to consider all appeals made by a GMS/GDS/PDS Contractor against decisions reached by the Primary Care Panel in relation to any contractual matter. These will include, but not be restricted to:

- Branch Surgery Closures
- List closures
- List size reductions
- Boundary Changes
- Dispensing Practice Applications
- Changes to contracted activity levels and Units of Dental Activity/Units of Orthodontic Activity (UDA/UOA) values in relation to GDS contacts
- Conversion from PDS to GDS contract status
- Contract compliance and performance

3. Membership

Membership of the panel will comprise:

Independent BCU Board members x 3, nominated by the BCUHB.

The Panel will appoint a Chair from within its membership.

In attendance:

Assistant Director - Primary Care Support
Area Head of Primary Care (from Area in which the contractor is operational)

Other BCUHB Officers and PHW representative as required by the agenda or requested by the Chair.

4. Quorum

The meeting will be quorate if a minimum of 2 members are in attendance.

5. Frequency of Meetings

The Panel will meet as and when required to attend to appeals relating to primary care contractual matters

6. Reporting

The Panel will report its decisions to the Health Board for information.

7. Administrative arrangements

Minutes of the meeting, detailing key areas of discussion, decisions and actions agreed will be recorded. Papers and agenda will be circulated at least 5 working days before the meeting, and the draft minutes will normally be presented to the Chair of the Group within 6 working days of the meeting, for distribution to the Group within 10 working days.

First review date: 23 October 2015 (version 0.1)

Next review date: October 2016