Cyfarfod a dyddiad: **Meeting and date:**	**Audit Committee** **10 June 2021**
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Proposed Integrated Governance Framework
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Gill Harris Executive Director of Nursing and Midwifery, Deputy Chief Executive
Awdur yr Adroddiad **Report Author:**	Simon Evans-Evans Interim Director of Governance
Craffu blaenorol: **Prior Scrutiny:**	Executive Leadership Team Board Workshops
Atodiadau **Appendices:**	Proposed Governance Framework 1.15 Proposed Governance Framework 1.15 Clean Executive Summary Draft Terms of Reference • Audit Committee • Remuneration and Terms of Service Committee • Charitable Funds Committee • Mental Health Capacity and Compliance Committee • Power of Discharge Group • Partnerships, People and Population Health Committee • Performance, Finance and Information Governance Committee • Quality Safety and Experience Committee • Executive Leadership Team Draft Report Template Draft Agenda Template Draft Chairs' Assurance Report Equality Impact Assessment (EQIA)

Argymhelliad / Recommendation:

1. **Approve the suite of documents for presentation to the Board**

Please tick as appropriate

Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval	✓	**Ar gyfer Trafodaeth For Discussion**		**Ar gyfer sicrwydd For Assurance**	✓	**Er gwybodaeth For Information**	
Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol **Y/N to indicate whether the Equality/SED duty is applicable**							**N**

If this report relates to a 'strategic decision', i.e. the outcome will affect how the Health Board fulfils its statutory purpose over a significant period of time and is not considered to be a 'day to day' decision,

then you must include both a completed Equality Impact (EqIA) and a socio-economic (SED) impact assessment as an appendix.

Sefyllfa / Situation:

The Health Board (HB) and Welsh Government has identified governance as an area that needs improvement, Simon Evans-Evans has conducted a review, building on previous reviews, interviews with Board members and support from internal teams including the Office of the Board Secretary, the office of the Chief Executive, the Executive Leadership Team and the Equalities Team. The proposed framework intends to

- Ensure that the governance, performance management and risk structures are effective, efficient and robust.
- Ensure clear accountability at all levels and that the HB creates an environment for learning and safety.
- Ensure that governance standards are consistent through the organisation.

Cefndir / Background:

Objective 1: Ensure that the work of the Board and committees are pitched at the right level and balance their responsibilities in strategy, culture and accountability.

By undertaking some of the analytical, research, and evaluation work the committees, Executive Delivery Groups and associated Tactical Groups will create space for the Board Committees to balance their agendas. Proactive use of the Cycles of Business, associated agendas and meeting evaluation will highlight the balance of time a committee spends in each area. The quality of the evidential reports provided by Executive Delivery Groups and Executive Management Groups will be key to ensuring the pitch of oversight vs detailed investigation is met. Where aligned, the Executive Delivery Group will take lead responsibility for co-ordinating reporting from Executive Management Groups and Executive Delivery Groups to ensure consistent reporting between the present and the progress along the transformation route.

Draft Cycles of Business for the three “strategic” Board committees are drafted in Appendices 18-20 of the Proposed Governance Framework 1.14

Objective 2: Develop a greater focus on strategy in committee – delivering for the future.

Incorporating relevant strategies into each committee terms of reference, combined with defining committee responsibilities within the corporate strategy will clarify ownership of strategy; this together with an aligned delivery structure reporting into the committees should provide the framework to appropriate focus on strategy.

Draft Agenda template is attached, linked to the Draft Cycles of Business.

Objective 3: Improve the focus, co-ordination and relevance of Board and committee papers with built in assurance levels.

The effect of consistent use of the Chairs Assurance Reports, together with the strategic, tactical, operational delivery structure and no orphaned groups rule will improve accountability (linked to the Performance and Accountability Framework) and ultimately assurance in that where challenges,

celebrations, concerns and commendations are not escalated will be easier to trace back, understand why and learn.

The effective use of cycles of business and committee agendas will also allow for a balance of committee business within the meeting, and across the year to support Independent Members to get a deeper understanding of the challenges, celebrations, concerns and commendations within the operational teams.

Draft Chairs Assurance report is attached, note that in both the draft agenda and the chairs assurance report the levels of assurance is quantified, aligned to the assurance levels used in the BAF based on the three lines of defence model board members are familiar with.

Objective 4: Give the Board clear line of sight over business as usual and strategic delivery structures, including lines of accountability to provide better assurance and reduce duplication.

The structure aims to give a clear line of accountability for performance through the Executive Management Groups, supported by the Performance and Accountability Framework and the Performance Oversight Group. Enabling the Chief Executive to hold Executive Directors to account for performance and the Board to hold the Executive Leadership Team to account for performance management. (Also this partly meets objective 4).

Objective 5: Develop greater oversight of the People / Transformation agenda.

Covered within the Terms of Reference for the Partnerships, People and Population Health Committee.

Objective 6: Improve information flow: no orphan groups - improve the line of sight from Floor to Board through increased governance discipline.

This will be resolved through having clear reporting lines for groups and committees, linked to consistent use of the chairs assurance reports, which will highlight areas of challenges, celebrations, concerns and commendations. Committees and Board will also have the opportunity to hear first-hand from the front line during the programmed directorate reviews within the cycles of business.

Asesiad / Assessment & Analysis

The attached frameworks are intended to support BCUHB out of Targeted Intervention and focus the organisation on delivery of key priorities, Executive Delivery Groups will be able to support Board and Committees develop strategy, including the prioritisation of improvement metrics.

Proposed Governance Framework 1.15 / Proposed Governance Framework 1.15 Clean

A track changes version has been provided to show changes made following feedback at the Board Workshop on 27 April 2021.

The new suite of templates are branded.

Draft Report Template

This template has changed slightly.

Summary Changes:

- The Welsh and English titles have been separated to facilitate easier reading
- Assurance level has been incorporated within “report purpose” to align to the BAF
- Annual Plan priorities have been included as a drop down
- Annual Plan enablers have been included as a drop down
- Targeted Intervention Improvement Framework (TIIF) priorities have been included as a drop down
- Direct reference to current BAF / Tier 1 risks included
- New section on Engagement included
- New sections on PSED / SED included

Draft Agenda Template

This template has changed Six sections to mirror Cycles of Business within the governance proposals (following the Hywel Dda UHB model)

Summary Changes:

- The Governance section to include verbal / written report from Chair and Lead Director, and notification of matters referred from Board or another committee
- Strategic items for decision – both strategy development and monitoring will appear here
- Quality, Safety and Performance – the present – performance reports etc. will appear here
- Learning from the past – investigation reports etc. will appear here
- Chairs assurance reports – to provide line of sight and assurance
- Closing business to include a review of risks highlighted during the meeting as well as a review of the meeting effectiveness.

A Draft PowerPoint slide deck is being prepared for the rolling Directorate reporting to Committees

Draft Chairs Assurance Report

Summary Changes:

- Assurance level has been incorporated within “Key assurances” to align to the BAF

Draft Terms of Reference

Summary Changes:

- Requirement to meet Public Sector Equality Duty (PSED) and Socio Economic Duty (SED)
- Right of attendance to the Chair of the Board and Audit Committee and Board Secretary

Executive Attendance

	Audit	*MHCC*	*RaTS*	*CF*	*QSE*	*PPPH*	*PFIG*
Chief Executive (1)	x						
Deputy Chief Executive and Executive Director of Nursing & Midwifery (6)	x	x	Lead		lead	x	x

Executive Medical Director (5)			x	x	x	x	x
Executive Director of Primary Care and Community Services (4)		x	x		x	x	
Executive Director of Planning and Performance(3)				x		lead	x
Executive Director of Finance (3)	x			Lead			lead
Executive Director of Therapies and Health Sciences (3)			x		x	x	
Executive Director of Public Health (3)		lead			x	x	
Executive Director of Workforce and Organisational Development (3)					x	x	x
Board Secretary (1)	Lead						

The development of the proposed governance framework has been iterative, with comments from Board, Executive Leadership Team, Executive Management Group, Office of the Board Secretary, Office of the Chief Executive, and the equalities team.

Options considered

There is no single right solution to governance frameworks, these models have been designed and developed following conversations with senior personnel within BCUHB and will need the support of leaders within BCUHB to be successful.

Financial Implications

No analysis has been made of the financial impact, although the frameworks are designed to make the organisation more efficient in its decision making and more robust in its financial and performance management, which should have a positive impact in the accounts. No assessment has yet been made on the levels of corporate support that could be required to support news ways of working, understand risk etc.

Risk Analysis

Detailed risk analysis has not been undertaken although the do-nothing option would appear high risk in the eyes of the Board and Welsh Government; there may be risks that will need to be managed in the socialisation and implementation stages.

Legal and Compliance

Specific legal advice has been sought on the relationship of the Power of Discharge Group, the model being adopted follows Cardiff and Vale UHB.

Impact Assessment

An Equality Impact Assessment has been completed.

Embedding the principles of equality and human rights at heart of the Integrated Governance Framework enables and promotes compliance with the three aims of the Public Sector Equality Duty. The framework explicitly states that one of the core purposes of the Health Board is to reduce inequality and promote equality and human rights.

Given the nature of Committee membership and therefore of strategic decision making consideration should be given to ensuring inclusive representation to reflect the diverse demographic of North Wales where possible.

Proposed Integrated Governance Framework 2020

Simon Evans-Evans

v1.15

Contents

1. Rationale

1.1. Background

The Welsh Government placed the Health Board into Special Measures on 8 June 2015 with the intention that we would be able to demonstrate progress and move down through the four 'escalation' levels:

- Special measures.
- Targeted intervention.
- Enhanced monitoring.
- Routine arrangements.

In May 2019, maternity services and GP out-of-hours were taken out of Special Measures and on 24 November 2020, following advice and recommendation from the tripartite meeting of NHS Wales, Audit Wales and Healthcare Inspectorate Wales the Welsh Government stepped the Health Board down from 'Special Measures' to 'Targeted Intervention'.

During Special Measures and Targeted Intervention, the Welsh Government has highlighted Governance as an area that the Health Board needs to improve.

1.2. Findings

In this review process during a series of one to one interviews, board members raised a number of concerns including, but not limited to:

- Lack of sight from the Board through the organisation to the front line.
- Too much board and committee time focused on detailed operational matters.
- Not enough time at board and committee to focus on developing strategies.
- Lack of clear building blocks for governance (corporate strategy, performance management, road map out of special measures, prioritised medium and long term planning).
- Holding execs to account is important, but developing strategy and culture is more important and is missing.
- No co-ordinated oversight from the Board in relation to "our greatest asset" – our people.
- No visibility from the Independent Members in the operational support structure to give assurance against statements made by Executives.
- Lack of confidence from the Independent Members that Executives are delivering what has been agreed.
- Visibility of Executives through the organisation.
- Inadequate individual performance management.
- The board has two groupings (Independent Members and Executive Directors), is not acting as a unitary Board and there is a lack of trust.
- Lack of a patient focus at Board level.
- Committees need clear structure and process to allow a balance of day to day versus strategic.

- Inadequate links between Board and organisational governance.
- Too much time spent on governance and oversight on writing reports and presentations.
- Too many meetings that Independent Members are required to attend.
- Board and committee meetings are too long and less productive towards the end.
- Poor information flow, inadequate use of information, data and analytics.
- No performance culture and lacking in consequence poor reporting culture.
- Need more transformational leadership and succession planning.

1.3. Governance outcomes within the Targeted Intervention Improvement Framework (TIIF)

The TIIF sets out outcomes the Welsh Government expect to see and reflects some of the comments made by Board Members and highlighted in section 1.2.

The TIIF states that the Health Board will need to agree its own approaches to the development and implementation of the matrices; however, as a guide the following section sets out the themes and challenges that the Welsh Government expects to be addressed. The overriding expectation of the framework is to ensure that:

- Ongoing transformation, improvement and innovation leads to improved trajectory of outcomes, patient experience and financial performance year on year.
- A revised accountability and performance framework delivers improvements in performance and patient safety.
- The health board builds on relationships and existing partnership structures and fully engages and involves the public, staff, trade unions and partners on the transformation and reshaping of services.
- A sustainable vision for the future is agreed and communicated to the public, staff, trade unions and partners.
- The development of a medium term plan, incorporating a robust three-year financial plan to meet its financial duties.
- The development and implementation of a long term integrated clinical services strategy.
- Strengthen leadership capacity and enhanced governance supports organisational development, decision making and resilience.
- Improvements will be celebrated, leading to de-escalation, as assessed by the maturity matrix approach.

The specific Governance and Leadership outcomes are indicative of the building blocks that need to be reflected in the transformation journey.

- Develop and embed a compelling vision for the Health Board that is understood, recognised and accepted throughout the organisation.
- Demonstrate visible clinical leadership engaging patients, partners and staff.

- An effective, integrated Board setting a clear strategic direction for the organisation.
- An open and transparent culture and willingness to learn.
- Consolidation of executive leadership supported by a development programme for the Executive Team.
- Collective responsibility for quality and patient safety across the executive team and clearly defined roles for professional leads.
- A revised accountability and performance framework, underpinned by a robust governance structure.
- Visibility and oversight of clinical audit and improvement activities across divisions/groups/directorates and at corporate level.
- A strong approach to organisational learning supported by a culture of high quality care.

1.4. What is the Integrated Governance Framework trying to achieve?

Organisational governance, culture and behaviour are inextricably linked. Colloquially governance can be described as "the way we do things around here"; culture can be described as "the way we do things around here – when no-one is watching". The proposed framework therefore needs to be supported by the Organisational Development Programme to address the behavioural and cultural issues raised by Board Members and the Welsh Government.

The framework also needs to align to the emerging corporate strategy, as the framework is the delivery and assurance structure for the strategy.

The framework aims to support the Board in its key functions of leading the Health Board to be effective and to deliver the principal role of a Health Board:

To ensure the effective planning and delivery of healthcare for people for whom it is responsible, within a robust governance framework, to achieve the highest standards of patient safety and public service delivery, improve health, reduce inequalities and achieve the best possible outcomes for its citizens, and in a manner that promotes human rights.

1.5. What are the objectives?

The governance proposals are designed to meet the follow objectives agreed by the Board:

Objective 1:

- Ensure that the work of the Board and committees are pitched at the right level and balance their responsibilities in strategy, culture and accountability.

Objective 2:

- Develop a greater focus on strategy in committee – delivering for the future.

Objective 3:

- Improve the focus, co-ordination and relevance of Board and committee papers with built in assurance levels.

Objective 4:

- Give the Board clear line of sight over business as usual and strategic delivery structures, including lines of accountability to provide better assurance and reduce duplication.

Objective 5:

- Develop greater oversight of the People / Transformation agenda.

Objective 6:

- Improve information flow: no orphan groups - improve the line of sight from Floor to Board through increased governance discipline.

2. The Integrated Governance Framework

2.1. What is the Integrated Governance Framework?

The Integrated Governance Framework sets out the means by which the Board and staff ensure that they are doing the right things, in the right way, for the right people, in a manner that upholds the values set for the Welsh public sector.

2.2. What do we mean by Integrated Governance?

Integrated governance can be defined as:

'Systems and processes by which we lead, direct and control our functions in order to achieve organisational objectives, safety, and quality of services, and in which we relate to the wider community and partner organisations.'

For the Board (and the organisation) to be effective, it has to be assured that integrated governance systems are closely intertwined. Each decision has to focus closely on the requirements of the different aspects of governance, in particular five governance arrangements collectively known as Integrated Governance or as a system just Governance:

- Clinical governance.
- Corporate governance.
- Research governance.
- Information governance.
- Financial governance.

The main features of an integrated governance model are:

- Integrating risk assessment with the initial objective setting.
- Developing a process for reporting progress against objectives.

- Aligning the various governance systems so that they complement each other without overlap.
- Developing an effective assurance framework.
- Ensure the committee structure is fit for purpose.

Governance provides a focus on:

- Vision.
- Strategy.
- Leadership.
- Assurance.
- Probity.
- Stewardship.

2.3. What is the purpose of Integrated Governance Framework?

Integrated Governance is the system that allows the Health Board and the Board to ensure the Health Board delivers its core purpose, namely:

- Effective planning and delivery of healthcare for people for whom it is responsible.
- A robust governance framework.
- Achievement of the highest standards of patient safety and public service delivery.
- Improve health.
- Reduce inequalities.
- Achieve the best possible outcomes for its citizens.
- Promote human rights.

Our Board is an Integrated Board which functions as a corporate decision making body. Executive Directors and Independent Members are full members and share corporate responsibility for all the decisions of the Board. However, for committees with a primary scrutiny function, membership is limited to Independent Members, with Executive Directors in attendance:

The three key roles through which effective Integrated Boards demonstrate leadership are:

- Formulating strategy.
- Ensuring accountability by holding the organisation to account for the delivery of the strategy and through seeking assurance that systems of control are robust and reliable.
- Shaping a positive culture for the Board and the organisation.

Key Board Role	Independent Members' role	Executive Directors' role
Formulating Strategy	Joint Responsibility	Joint Responsibility
Ensure Accountability and Delivery	Support and Assurance	Delivery and Assurance
Shape Culture	Joint Responsibility	Joint Responsibility

2.4. What is assurance?

Academi Wales describes assurance as:

Providing: 'Confidence' / 'Evidence' / 'Certainty'.
To: Directors / Non-executives / Management.
That: What needs to be happening is actually happening in practice.

NHS Boards may seek and receive assurance from a wide range of sources within their organisation, both directly and through the operation of its committees, notably those responsible for Audit and for Quality & Safety. The key challenge for Boards is understanding each link in the assurance chain, what part it plays in the overall framework of assurance, and the value they should place on it. The Audit Commission (2009b) describes an approach to internal assurance as a "three lines of defence" assurance model:

First line of defence: Responsibility lies with healthcare staff and teams working at the 'frontline' to understand their roles and responsibilities and to carry them out properly and thoroughly. If working practices (the 'systems and processes') are well designed, and staff are equipped to follow them, compliance with the arrangements should mean risks in day-to-day activities are routinely managed.

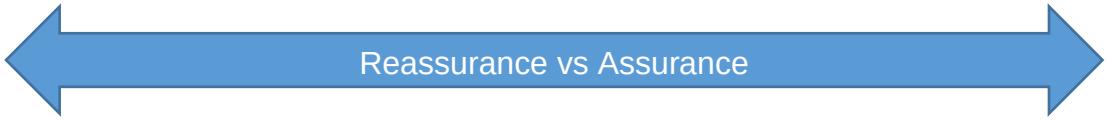
Second line of defence: This typically comprises executive/management arrangements established to ensure compliance with the standards, policies and working practices set through active oversight of the operation of the first line of defence. Typically, this includes holding them to account for the effectiveness of their activities, and may include routine assessment, inspection and review activity to ensure the achievement of standards and compliance with policies and procedures.

Third line of defence: This is independent review, designed to assess the overall adequacy and effectiveness of the first and second lines of defence. The key source of this 'independent' assurance is through functions such as internal audit, although there are other sources of independent review that can also be used, including inspectorates and review bodies. (Academi Wales)

NOTE: The Board Assurance Framework defines the levels of assurance on controls as

0 – Policies in place but not actively managed
1 – 1st Line: Department.
2 – 2nd Line: Organisational.
3 – 3rd Line: Independent.

The three lines of defence are sometimes referred to as the reassurance versus assurance continuum:



It is OK because management says it is	It is OK because management have responded to questions from the board and this has given me confidence	It is OK because I have reviewed various reliable sources of information

2.5. What are the principles in this Integrated Governance Framework?

- Set clarity for the Board and staff within the Health Board in relation to:
  - Assurance.
  - Accountability.
  - Decision making and approval.
  - Roles and Responsibilities.
  - Effective segregation of duties.
- Have clear alignment to:
  - The Health Board's principle role and purpose.
  - Welsh Government expectations.
  - Targeted Intervention Improvement Framework.
  - Health Inspectorate Wales expectations.
- Provide a model that aligns to:
  - Quality management (Patient experience, Patient safety and Clinical effectiveness).
  - Innovation, learning and modelling new ways of working.
  - Risk Management and Board Assurance Framework.
  - Performance and Accountability Framework.
  - Strategy delivery.
  - People management.
  - Financial management.
  - Data management.
  - Process and policy development.

2.6. Framework design

To aid clarity of purpose in groups and committees. The model is intended to provide transparency on where and how we obtain assurance, responsibility for delivery, it takes into account the wider health systems and requirements in Wales and aligns wider governance structures (as listed above). The framework also

guides groups as to their purpose in the Health Board, Assurance or Delivery, Strategic, Tactical or Operational.

The proposed BCUHB model has the Integrated Board supported in its assurance and culture setting roles by good and solid **Process Management** (including Risk, quality systems, Equality Impact Assessments to assure the promotion of human rights etc.). Good **Performance Management** (helping to give sight from floor to Board and to see outcomes) and a co-ordinated focus on **prevention**.

It is supported in is strategic and culture setting roles by focusing on 4 domains;

- **Population Health** (improving health, reducing inequalities).
- **Patients** (best possible outcomes).
- Our **People** (not just well-being and recruitment, but planning for the future, education enabling the organisation to deliver on a Transformation programme etc.).
- Finances **(Pounds).**

All of the above is evidenced or enabled by the **Operational Delivery, Digital Enabler, Learning Innovation and Best Practice** and by **Working in Partnership**

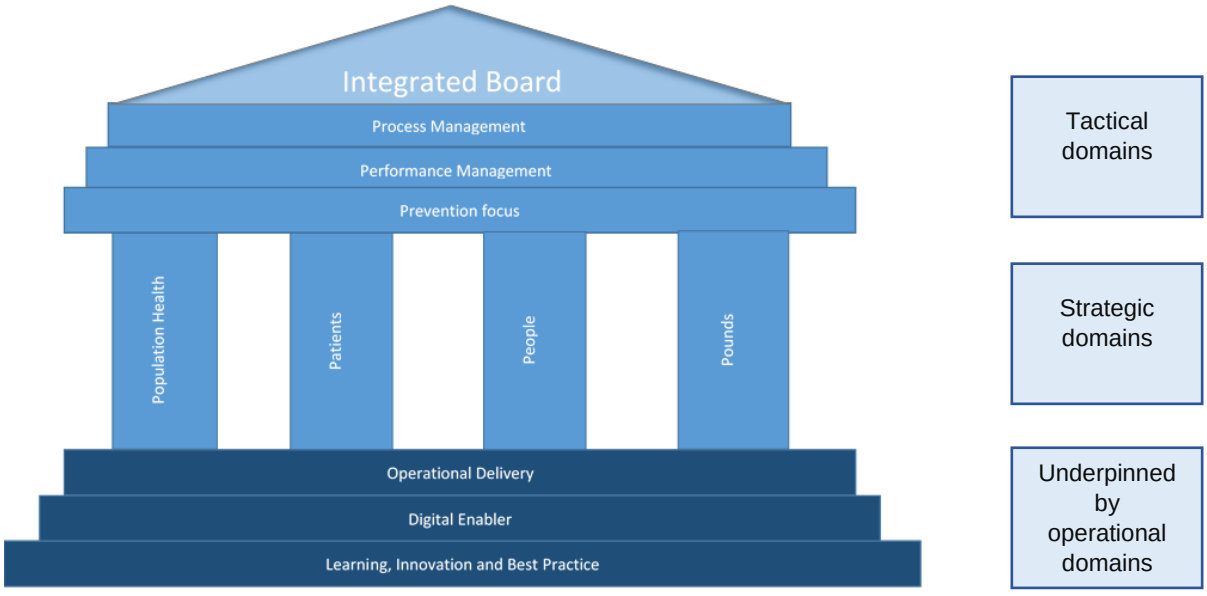


Figure 1 : The Betsi Model of Governance

3. The Integrated Governance Framework in practice

The Good Governance Guide for NHS Wales is clear where independent Members and Executive Directors have joint endeavour and where they have different roles. Board committees are formed to support the Board develop strategy, set culture and hold the Executive arm of the Board to account for delivery.

The Board as a whole is responsible for the WHAT and the Executive for the HOW. The Integrated Board agrees and sets the vision, goals and priorities and the executive develop the strategies to deliver them. We can define strategy as "the high level blueprint that articulates the vision and sets key milestones and measures of success". Once the strategies are approved, the Executive then develop the detailed plans for delivery and the Board measures and monitors progress and performance against the plan.

3.1. Board Structure

The Board is comprised of Independent Members and Executive Members, The Board functions as a corporate decision making body. Executive Directors and Independent Members are full members and share corporate responsibility for all the decisions of the Board. However, for Committees with a scrutiny function, membership is limited to Independent Members, with Executive Directors in attendance:

3.1.1. Purpose of Board committees

Board Committees are charged with supporting the Board to deliver on its purpose by:

- Setting and embedding culture.
- Developing and monitoring strategy.
- Holding the Executive Leadership to account for delivery (both operational delivery and strategic delivery).

Therefore, Board Committees can only have membership drawn from the Independent Members so as not to conflict Executive Members of the Board.

3.1.2. Board committee structure

The Board has three joint committees with other health boards in Wales to support pan Wales delivery and three advisory Groups as laid out in regulation, other Board committees are at the discretion of the Board (provided that certain functions are fulfilled[1]). In this model, all committees have a duty to support the Board in setting the culture of the organisation. There are:

- Three committees primarily focused on proving assurance and supporting the organisational culture within a relatively narrow remit.
    - Mental Health Compliance and Capacity Committee (MHCC).
    - Remuneration and Terms of Service Committee (RaTS).
    - Charitable Funds Committee (CC).
- Three committees primarily focused on strategy development & monitoring, supporting organisational culture and assurance. These committees also reflect the four strategic domains in the governance model (Patients, Pounds, People and Population Health).

[1] Oversight of: Audit; Quality and Safety; Information Governance; Charitable Funds; Remuneration and Terms of service; Mental Health Act Compliance

- Quality, Safety and Experience (QSE).
- Performance, Finance and Information Governance (PFIG).
- Partnerships, People and Population Health (PPPH).

- Audit Committee (AC) to review governance and assurance processes critically on which the Board places reliance.

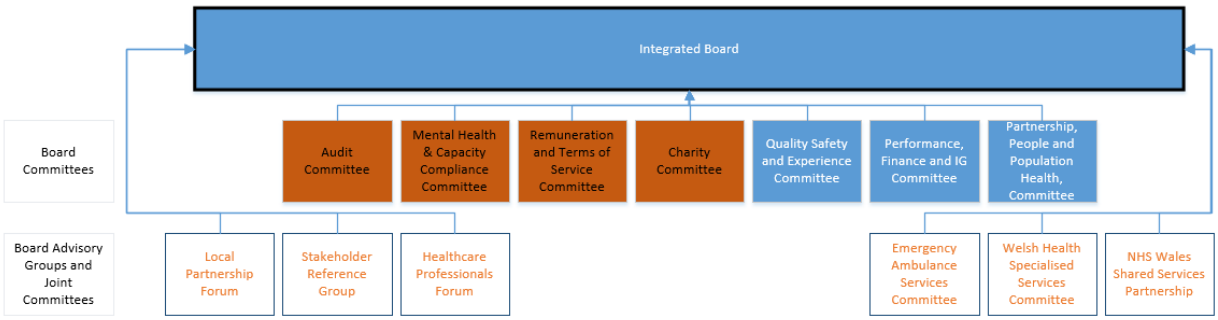


Figure 2 - Betsi Board and committee structure

3.1.3. Segregation of responsibilities

Whilst all members of the Board have joint responsibilities and all Board committees have joint responsibility in relation to setting and embedding culture and in ensuring organisational compliance and assurance, responsibilities are segregated to allow for effective check, challenge and assurance in relation to strategic and operational delivery. This ensures that Independent Members remain independent of operational matters and Executive Directors can be held to account for organisational performance. Figure 3 demonstrates the relevant roles and responsibilities of Board Committees and the Executive Leadership Team.

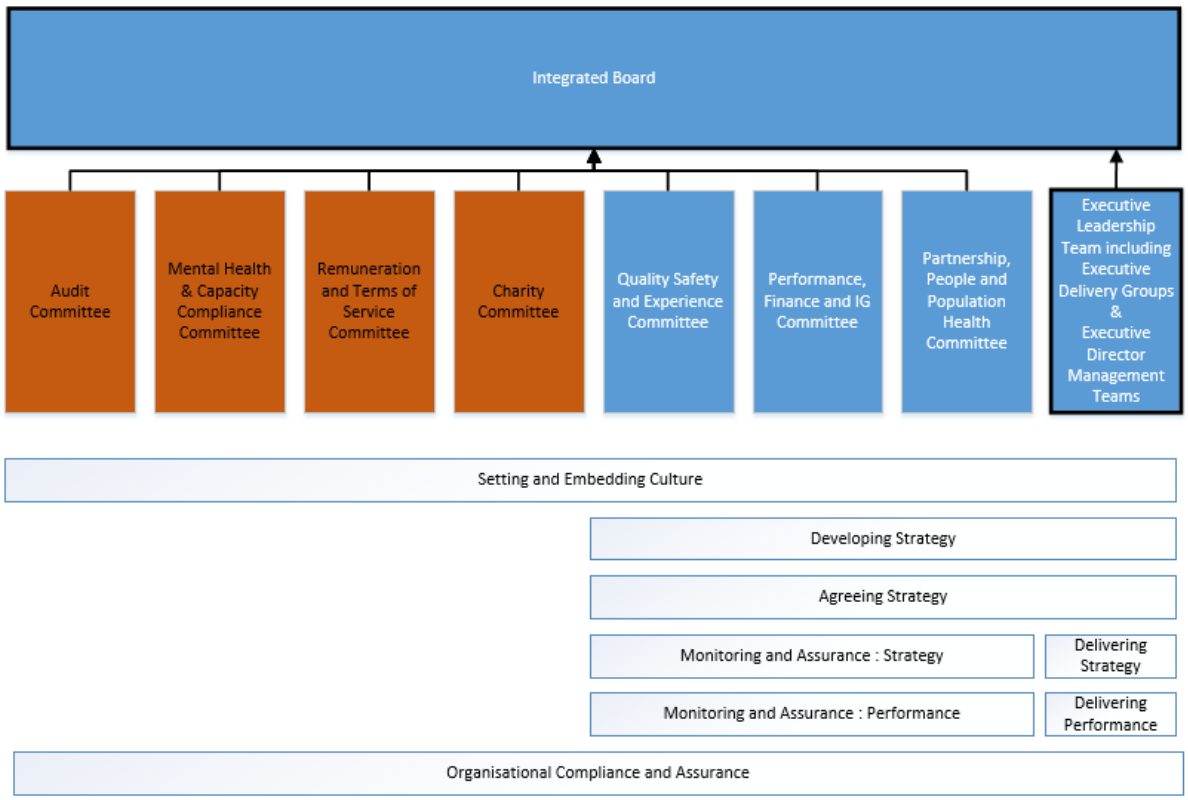


Figure 3 - Segregation of responsibility

3.1.4. What is different from the current model?

Current Committee	**New Committee**	**Changes**
Audit	Audit	No Change
Mental Health Act	Mental Health & Capacity Compliance	Focus on compliance with the Mental Health Act Removed mental health divisional quality assurance to 'mainstream' quality of mental health services and provision within the QSE
Power of Discharge Sub-committee	None	Changed form a formal sub-committee to a Power of Discharge Group for Hospital Managers reporting to MHCC Committee quarterly *(in line with CAVUHB)*
Remuneration and Terms of Service	Remuneration and Terms of Service	No change
Charitable Funds	None	No Change
Digital and Information Governance	None	Digital agenda moved to PHPP as an enabling strategy (although alignment of enabling

		strategies already in Strategy, Partnerships, Population Health Committee ToR) IG moved to PFIG
Quality, Safety and Experience	Quality, Safety and Experience	Wider focus to include quality of MH and primary care services, and quality related strategies
Finance and Performance	Performance, Finance and IG	Removed people agenda, focus to include IG and PFIG related strategies
Strategy Partnerships and Population Health	Partnerships, People and Population Health	removed Quality and Finance strategies, focus to include people and enabling strategies
Board Advisory Groups and Joint Committees		No Change

Other changes

- Remove the Joint Quality and Audit Committee meetings. QSE have clear ownership of the outcomes of audits and setting a risk based approach to the scope and number of audits. Audit committee to seek assurance on the process. Specific concerns / recommendations relevant to each committee can be addressed through the committee by the role of the Independent Member link members and if necessary conversations between committee chairs.
- Chair and Chair of the Audit Committee to have right to attend all committees for assurance purposes.
- Reduce the frequency of the Board Secretary led Chairs business meetings to twice yearly.

The Board uses a committee structure to support its work.

The Executive Leadership Team is the delivery arm of the integrated Board responsible for delivering business as usual and strategy. Board committees are supported by Executive Delivery Groups (to delivery Strategy) and Executive Management Groups (to deliver operational performance). In turn, these are supported by Tactical Delivery Groups that will provide assurance reports to committees and undertake some of the detailed work for the committee; they will review and produce evidence to enable the Board committee to focus on its priorities during meetings. Tactical Delivery Groups will also be able to undertake and evaluate research to support the board develop strategies.

Figure 4 shows these groups and the assurance & information flows (in tan dotted lines) and reporting lines (in black lines). (See annexes 1-3 for individual committee details)

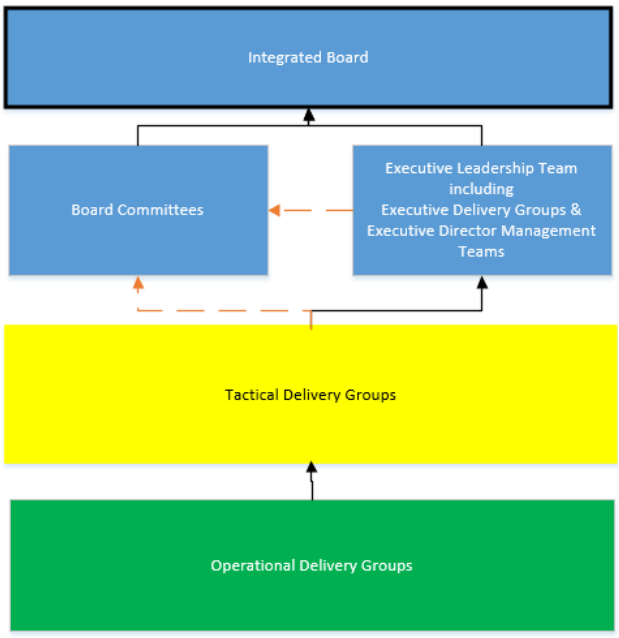


Figure 4 - Board and Executive Groups interface

3.2. Delivery Structure

The Executive Leadership Team heads the delivery arm of the Board in terms of both operational and strategic management. The Executive Leadership Team meets twice-weekly one meeting to focus on strategy the other to focus on operational delivery.

The model creates three cross-functional Executive Delivery Groups (EDG) for delivery of strategy. The Executive Delivery Groups are in effect an extension of the Executive Leadership Team, they derive their authority from the Executive Leadership team and are therefore accountable to the Executive Leadership team. However, they will work closely with Board committees and will provide reports and assurance directly to the Board Committees, for instance the Chair's Assurance Report will be a standing item on Board committee agendas (see section on Cycles of Business). The three EDGs are:

- Executive Delivery Group People and Culture.
- Executive Delivery Group Quality Improvement.
- Executive Deliver Group Transformation and Finance.

Each Delivery group will take on responsibility for co-ordinating and providing Board with evidence based strategic thinking in strategy development and providing evidence based assurance on delivery and impact.

The Delivery Group's responsibilities are configured differently to those of the Board Committees; this is to allow a different focus of challenge from at development and sign off stage.

These groups will drive the transformation agenda. They will ensure that the tactical and operational groups beneath them are functioning effectively (this is to become a standard role for each group wherever it sits in the structure which will enhance the effectiveness of meetings, line of sight from floor to board and support the functioning of the performance and accountability framework). Each Executive Delivery Group Chair will provide a Chairs' Assurance Report for the relevant Board committee, which may be shared with other committees for information to support common understanding of strategy delivery across the Board Committees.

To support the Executive Leadership Team and strategic Board Committees there will be a tactical Planning and Strategy Group to coordinate planning, strategy development and alignment of strategic delivery. Time limited groups are in place to deliver on Board operational priorities.

Operational management will be conducted through the Executive Management Groups, which in essence are the current Senior Management Team meetings in each directorate. The purpose of these groups is to provide evidence-based plans for improvement and evidence based assurance on operational delivery and outcomes, the Executive Management Groups will also provide evidence and assurance directly to Board Committees.

This structure will enable the Executive Leadership Team (ELT) to manage and balance its working arrangements in relation to strategic leadership and operational leadership.

The Executive Leadership Team will be responsible for ensuring that there are no "orphaned" groups so a proper governance and reporting structure beneath them for Tactical and Operational delivery. To avoid a renewed meeting culture any new group within the corporate structure will need ELT sign off.

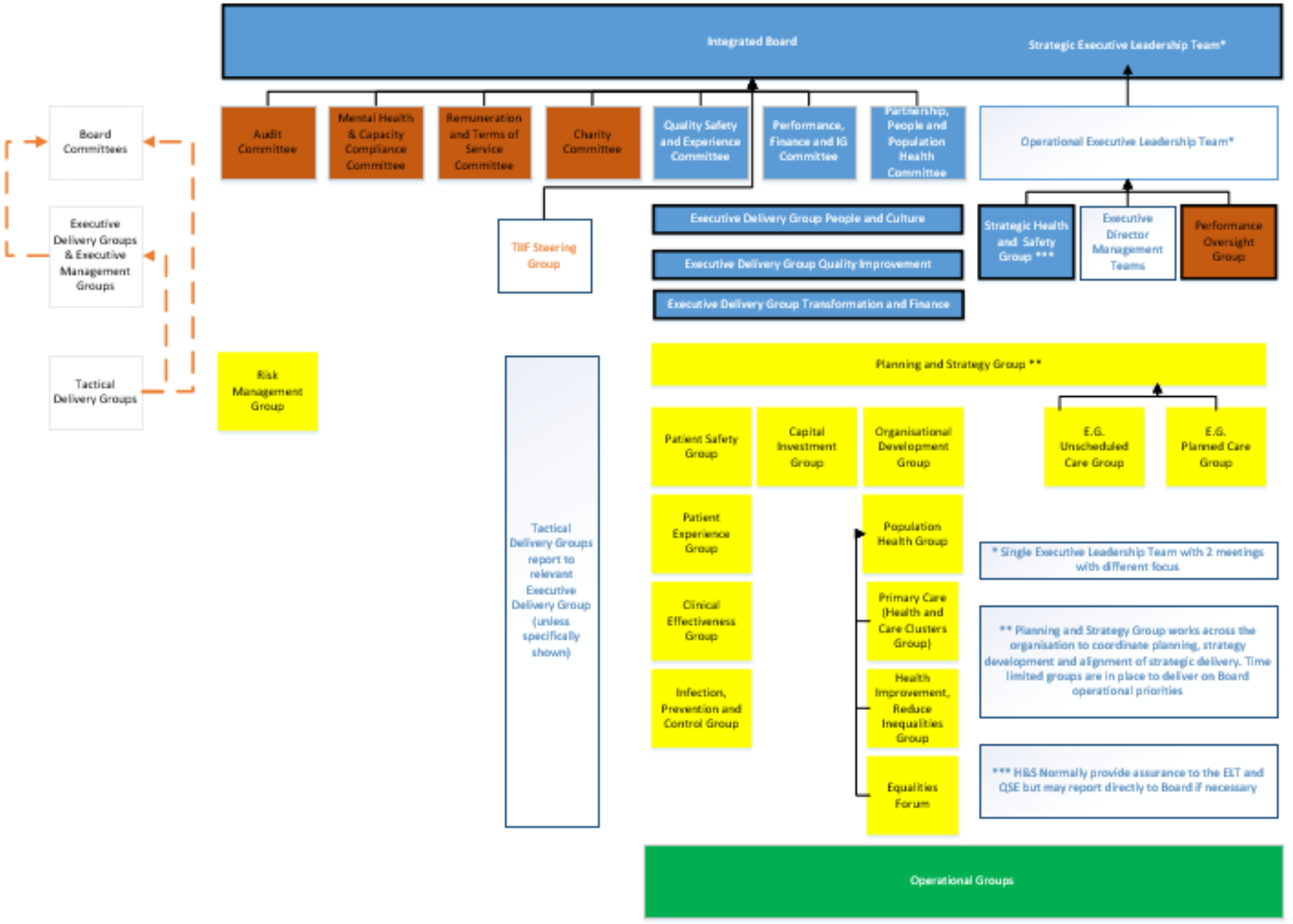

Integrated Board
Strategic Executive Leadership Team*
Board Committees
Executive Delivery Groups & Executive Management Groups
Tactical Delivery Groups
Audit Committee
Mental Health & Capacity Compliance Committee
Remuneration and Terms of Service Committee
Charity Committee
Quality Safety and Experience Committee
Performance, Finance and IG Committee
Partnership, People and Population Health Committee
Operational Executive Leadership Team*
TIIF Steering Group
Executive Delivery Group People and Culture
Executive Delivery Group Quality Improvement
Executive Delivery Group Transformation and Finance
Strategic Health and Safety Group ***
Executive Director Management Teams
Performance Oversight Group
Risk Management Group
Tactical Delivery Groups report to relevant Executive Delivery Group (unless specifically shown)
Planning and Strategy Group **
Patient Safety Group
Capital Investment Group
Organisational Development Group
E.G. Unscheduled Care Group
E.G. Planned Care Group
Patient Experience Group
Clinical Effectiveness Group
Infection, Prevention and Control Group
Population Health Group
Primary Care (Health and Care Clusters Group)
Health Improvement, Reduce Inequalities Group
Equalities Forum
* Single Executive Leadership Team with 2 meetings with different focus
** Planning and Strategy Group works across the organisation to coordinate planning, strategy development and alignment of strategic delivery. Time limited groups are in place to deliver on Board operational priorities
*** H&S Normally provide assurance to the ELT and QSE but may report directly to Board if necessary
Operational Groups

Figure 5 - Integrated Board Schematic

3.2.1. Strategic Tactical and Operational model

The Strategic Tactical and Operational model makes clear the purpose of groups, it limits the number of groups that can be seen as purely for assurance, moves away from groups having a purpose to 'assure' to groups having a purpose to 'deliver'. The evidence of delivery becomes the assurance. This model will be reflected in the Divisions, this structure, together with the Performance and Accountability Framework and the Chair's Assurance Reports starts to give more assurance of action and sight of front line teams to the Board.

3.3. Governance Handbook – ways of working

3.3.1. Cycles of Business

Cycles of business should be used to proactively manage the workload of committees and groups, streamlined to focus committee time to the most appropriate agenda's and comply with committee terms of reference.

Committees will be supported by an executive delivery structure to provide evidence and assurance and do some of the detailed work for the committees. The Cycles of Business are structure to support Board and committees balance their roles in strategy (the future), assurance (the present and learning from the past) while embedding culture. They are designed to cover all the Board and committee business over a year, but to give flexibility through Particular Areas of Concern Reports and the focus of the deep dives.

Innovations introduced in the attached committee cycles of business include:

- Having a patient story at Quality Committee.
- Standard report from the Chair to include feedback from Board.
- Standard report from the Lead Executive to inform members of matters that are important or innovative but would not require a full paper.
- Standard agenda item to receive feedback or notifications from other Board Committees.
- Inclusion of Directorate Operational Reports on a rolling basis to support the committee to get a broader view of activity within the organisation including challenges, celebrations, concerns and commendations and support the floor to board line of sight.
- Rolling Deep Dive Reports to allow meetings to focus on areas of responsibility and not take a shallow view at every meeting.
- Standard agenda item to refer matters to other Board Committees, if appropriate.
- Standard agenda item to review risks highlighted within the meeting and refer to the Risk Management Group if appropriate.
- Standard agenda item to agree items for the Chairs' Assurance Report.
- Standard agenda item to review the effectiveness of the meeting.

3.3.1.1. Themes to support the Golden Thread from floor to Board

- Patient Story at Board and QSE Committee. This could be implemented immediately.
- Directorate Reports at Board and committee on a rotational basis covering challenges, celebrations, concerns and commendations. This could be implemented immediately.
- Deep dive into areas programmed across the business year to give a depth of focus in a meeting rather than a shallow overview at every meeting. This could be implemented immediately.
- Report of Lead Executive at committees to make members aware of issues not suitable for a full paper, this could be an oral or written report. This could be implemented immediately.
- Formal process to refer matters to other committees and receive matters from Board. This could be implemented immediately.
- Identification of risks arising within a meeting for referral to the Risk Management Group. This could be implemented immediately.
- Chairs' Assurance Reports from relevant groups into committees for assurance and information. This could be implemented immediately.
- Formal reporting (via the lead Executive) from formal partnership arrangements and advisory groups to appropriate committees. This could be implemented immediately.
- Reviews of meeting effectiveness to capture learning and improvement.

3.3.2. Strategy Development and Monitoring

The Corporate Strategy (Living Healthier, Staying Well) is the top-level strategy that sets the direction for the organisation over the next period, a number of other strategies in specific areas will support the Corporate Strategy. Board oversight of the development and delivery of the Corporate Strategy will be via the Partnership, People and Population Health Committee, although other committees will have ownership of their section of the Corporate Strategy notably the Quality Safety and Experience Committee and the Performance, Finance and Information Governance Committee.

As the top-level strategy, the Corporate Strategy should identify the need for strategies for Board ownership (tier 1) and sub-strategies for Board information and committee ownership (tier 2). All strategies should be aligned to a Board Committee for ownership (where a strategy crosses the work of more than one committee the Board shall decide which committee takes primacy over the strategy).

Tier 1 (Board level strategies)

- Committees to develop strategy in accordance with the Corporate Strategy endorse and recommend to Board.
- Once Strategies approved committee will monitor implementation 6-monthly and report to board.

Tier 2 (Committee level strategies)

- Committees to develop strategy in accordance with the Corporate Strategy and any superior strategy and approve and notify Board (through the Chairs' Assurance Report).
- Committee will monitor implementation 6-monthly and report to Board (through the Chairs' Assurance Report) unless an area of specific concern or recommendation requires a full Board paper

When a strategy is presented to Board or committee, it should have a clear assurance paper attached to demonstrate.

- Audit of engagement.
- Outcome from engagement and consultation with
    - Staff.
    - Patients.
    - Partners.
    - The Public.
- Golden thread from the corporate strategy.
- Equality Impact Assessment.
- Public Sector Equality Duty (including socio-economic duty)

Where a strategy may impact the work of another committee either the Lead Executive or the common Independent Member committee member may refer all or part of a strategy to another committee for review.

3.3.3. Policy development and monitoring

Policies will be defined as

- Polices reserved for Board Approval (to be endorsed by relevant committee).
- Policies reserved for committee approval (to be endorsed by relevant Executive).
- Policies reserved for Executive Approval.

Through the Chairs' Assurance Report / Lead Executives report a list of approved policies from the tier below will inform the committee or Board of policies that have been approved for information and challenge (re level of sign off) as appropriate.

3.3.4. Other ways of working

- Coordinated Agendas and Cycles of Business, the future, the present and learning from the past.
- Consistency in use of the Cover Sheets.
- Agenda setting: Independent Member Chair and lead Executive Director should draft the agenda based on the Cycle of Business and noting Particular Area of Concern reports, deep dives, directorate presentations and Chair s Assurance reports from junior Groups. Once the draft agenda is approved by the committee chair it cannot be changed without the express permission of the committee chair.
- Agenda to link risks identified in meetings back to the Risk management Group and have formal information flow between committees.

- Consistent use of Chair's Assurance Reports to parent group for assurance and accountability.
- Consistent Terms of Reference: parent groups responsible for:
    - The governance structures beneath them.
    - Regularly testing the information cascade / escalation.
    - Identifying 'orphaned' groups within their remit.

3.4. Governance in practice – Scenarios

3.4.1. Risk – Primary and triangulation routes

A member of staff in primary care identifies a significant risk. The member of staff discusses the risk with their line manager and raises it on Datix.

- Primary Route – Datix - the risk should then be discussed at team meetings and depending on the risk score will rise to divisional risk meetings through to the Risk Management Group, Executive Leadership Team and relevant Board Committee.
- Route 2 – Performance and Accountability Framework – all performance meetings (throughout the organisation) should discuss risks – not just those currently on the risk register but also emerging risks, this route should rise through to the Performance Oversight Group and thereon to Executive Leadership Team and relevant Board Committee. A regular meeting is in place between the Performance Team and Risk Team to cross-reference risks that have been reported on Datix and those raised in performance meetings.
- Route 3 – Standard Meeting Practice - risk should be a standard agenda item on all meeting agendas (including the identification of new risks within the meeting (see proposed Board Cycles of Business (annexes 18-20)). Appropriate risks should be included in the Chairs' Assurance Report for information or escalation and through either line management or strategy delivery route to the appropriate Executive Director, Executive Leadership Team and Board Committee. If it is later discovered a risk was raised but not escalated this route also provides the evidence trail to better understand and learn why the risk was not escalated.

In principle, this also triple route also applies to incidents.

3.4.2. Floor to Board – Primary and triangulation routes

A member of staff in a hospital identifies an area of innovation or best practice. The member of staff discusses this with their line manager.

- Route 1 – Performance and Accountability Framework – all performance meetings throughout the organisation should discuss items to celebrate and things to be proud of, this route should rise through to the Performance Oversight Group and thereon to Executive Leadership Team and relevant Board Committee.
- Route 2 – Standard Meeting Practice – items to celebrate should be encouraged for discussion on all meeting agendas. Appropriate items should

be included in the Chairs' Assurance Report for information and through either line management or strategy delivery route to the appropriate Executive Director, Executive Leadership Team and Board Committee. If it is later discovered best practice was raised but not escalated this route also provides the evidence trail to better understand and learn why it was not shared.

- Route 3 - Board Committee Directorate Operational Reports – these will be designed to support Independent Members gain a more holistic oversight of the challenges, celebrations, concerns and commendations throughout the organisation.

3.5. How does this meet the objectives?

3.5.1. Objective 1: Ensure that the work of the Board and committees are pitched at the right level and balance their responsibilities in strategy, culture and accountability.

By undertaking some of the analytical, research, and evaluation work the committees Executive Delivery Groups and associated Tactical Groups will create space for the Board Committees to balance their agendas. Proactive use of the Cycles of Business, associated agendas and meeting evaluation will highlight the balance of time a committee spends in each area. The quality of the evidential reports provided by Executive Delivery Groups and Executive Management Groups will be key to ensuring the pitch of oversight vs detailed investigation is met. Where aligned, the Executive Delivery Group will take lead responsibility for co-ordinating reporting from Executive Management Groups and Executive Delivery Groups to ensure consistent reporting between the present and the progress along the transformation route.

3.5.2. Objective 2: Develop a greater focus on strategy in committee – delivering for the future.

Incorporating relevant strategies into each committee terms of reference, combined with defining committee responsibilities within the corporate strategy will clarify ownership of strategy; this together with an aligned delivery structure reporting into the committees should provide the framework to appropriate focus on strategy.

3.5.3. Objective 3: Improve the focus, co-ordination and relevance of Board and committee papers with built in assurance levels.

The effect of consistent use of the Chairs' Assurance Reports, together with the strategic, tactical, operational delivery structure and no orphaned groups rule will improve accountability (linked to the Performance and Accountability Framework) and ultimately assurance in that where challenges, celebrations, concerns and commendations are not escalated will be easier to trace back, understand why and learn.

The effective use of cycles of business and committee agendas will also allow for a balance of committee business within the meeting, and across the year to support Independent members to get a deeper understanding of the challenges, celebrations, concerns and commendations within the operational teams.

3.5.4. Objective 4: Give the Board clear line of sight over business as usual and strategic delivery structures, including lines of accountability to provide better assurance and reduce duplication.

The structure aims to give a clear line of accountability for performance through the Executive Management Groups, supported by the Performance and Accountability Framework and the Performance Oversight Group. Enabling the Chief Executive to hold Executive Directors to account for performance and the Board to hold the Executive Leadership Team to account for performance management. (Also this partly meets objective 4).

3.5.5. Objective 5: Develop greater oversight of the People / Transformation agenda.

Covered within the Terms of Reference for the Partnerships, People and Population Health Committee.

3.5.6. Objective 6: Improve information flow: no orphan groups - improve the line of sight from Floor to Board through increased governance discipline.

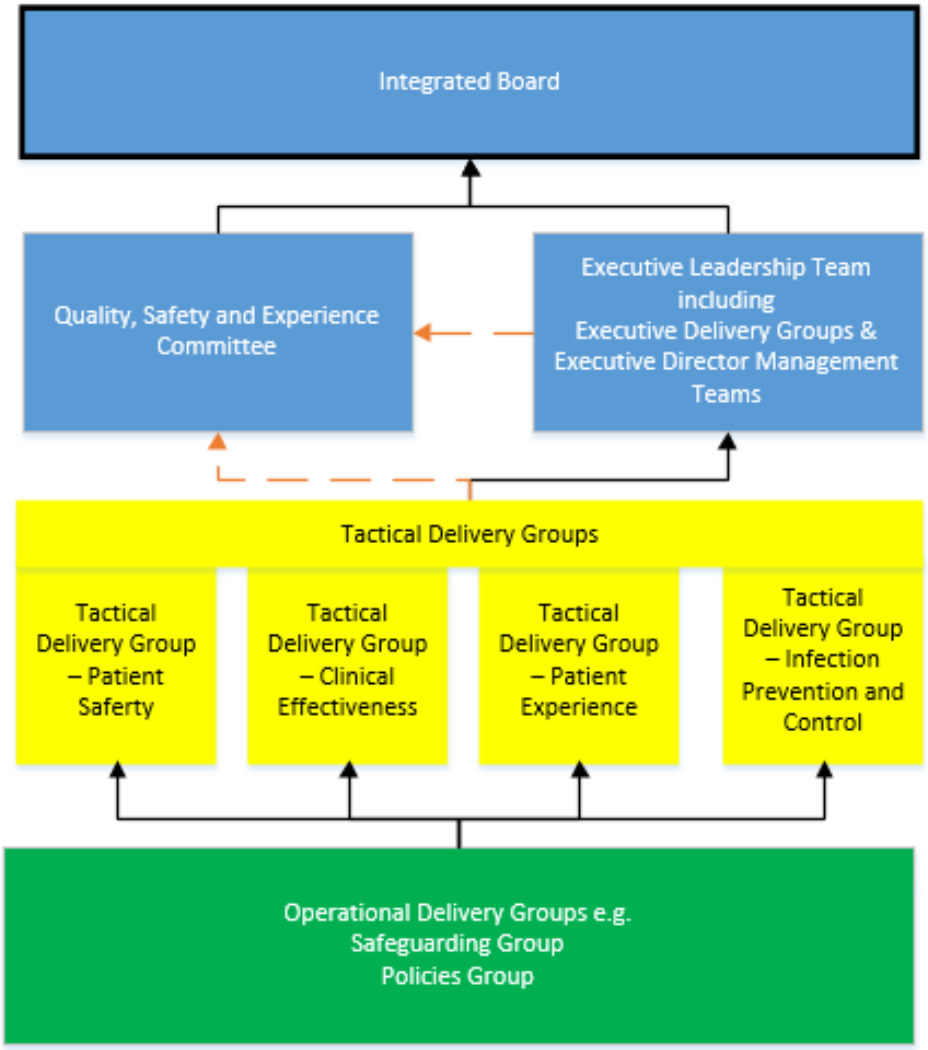
This will be resolved through having clear reporting lines for groups and committees, linked to consistent use of the Chairs' Assurance Reports, which will highlight areas of challenges, celebrations, concerns and commendations. Committees and Board will also have the opportunity to hear first-hand from the front line during the programmed directorate reviews within the cycles of business.

4. Indicative Timeline

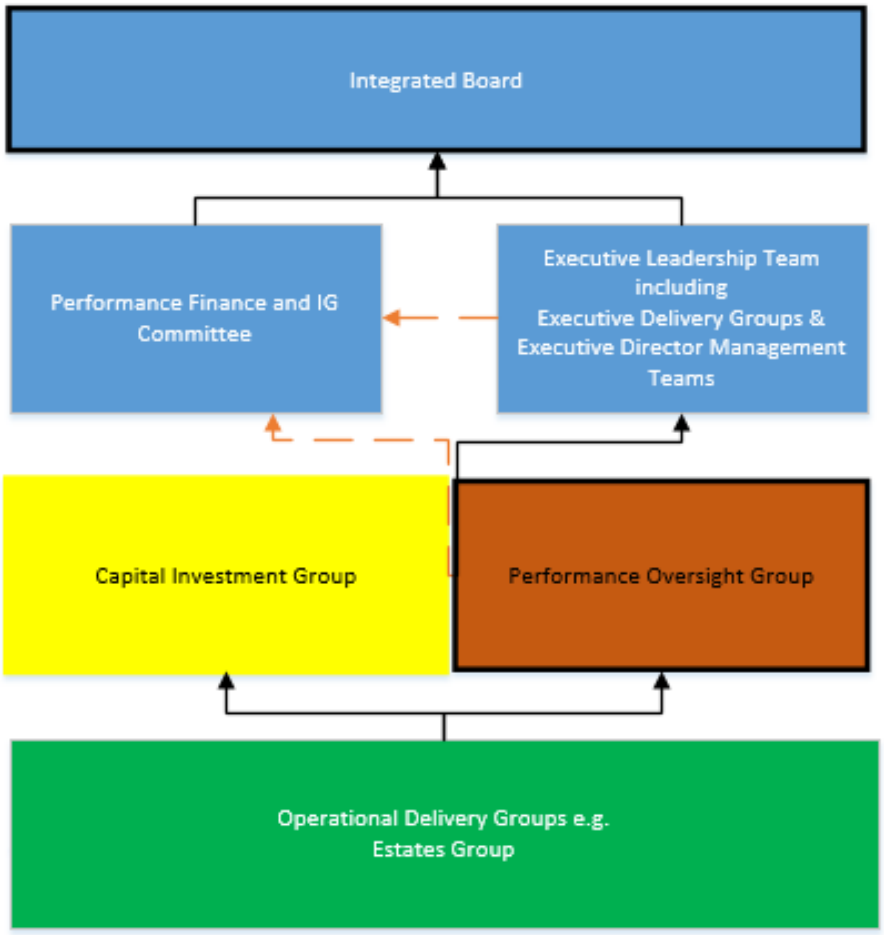
- 20 May 2021 — Board Approval in principle
- Full Workup
- 10 June 2021 — Audit Committee – Detailed workup approval (SO / ToR etc.)
- 01 August — Implementation

Annexes 1 – 3 Committee support structures

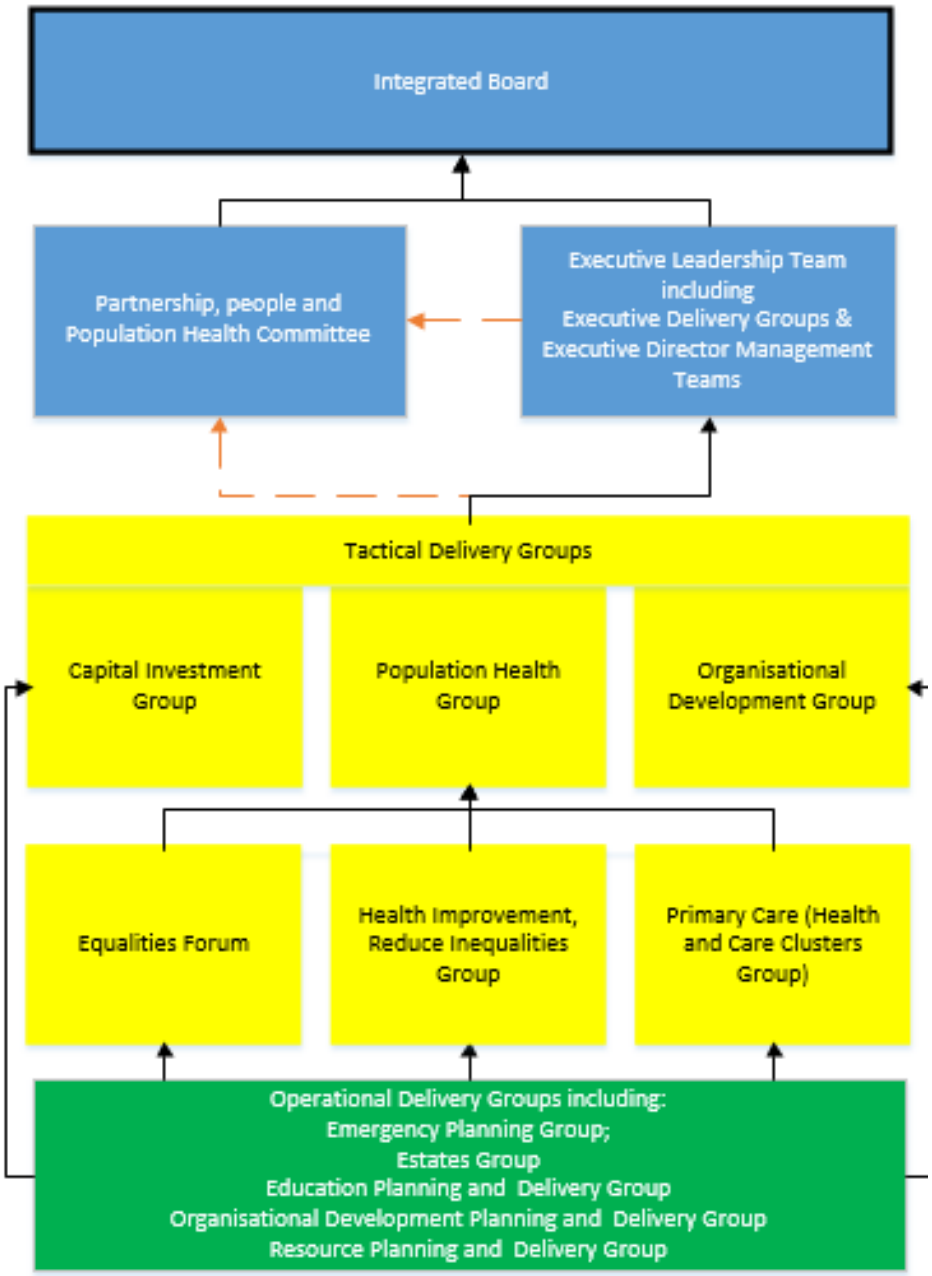
Annex 1 – Quality, Safety and Experience Committee Supporting Structure.



Annex 2 – Performance, Finance and Information Governance Committee Supporting Structure.



Annex 3 – Partnerships, People and Population Health Committee Supporting Structure.



Annexes 4 – 17 Outline Terms of Reference.

Annex 4 - *Commonality – Board Committees.*

Designation	WG requirement – Strategic Board Assurance Committee or BCUHB requirement – Strategic Board Assurance Committee

Purpose	Within the remit of the committee:
	1. Provide evidenced based assurance that there is compliance with:
	    1. The Equalities Act 2010.
	    2. In discharging its duty the Committee will have 'due regard' to the Public Sector Equality Duty, to eliminate discrimination, to advance equality of opportunities and foster good relations when carrying out all functions and day-to-day activities.
	    3. In discharging its duty the Committee will have 'due regard' to the Socio-economic Duty, to consider how strategic decisions might help reduce the inequalities associated with socio-economic disadvantage.
	    4.
	    5. The Human Rights Act 1998.
	    6. The United Nations Convention on the Rights of People with Disabilities.
	    7. BCUHB Policy.
	2. Provide evidence based and timely advice to the Board on developing strategies.
	3. Provide evidence based and timely advice to the Board on the delivery of strategies.
	4. Oversee and provide evidence based and timely advice to the Board on relevant risks and concerns.
	5. Receive the results of relevant audits (clinical and non-clinical) and any other relevant investigations and provide the Board with evidence based impact assessment of the implementation of the recommendations.
	        1. Seek assurance that outcomes for patients are delivered through partnership arrangements where that is beneficial for the patient
	6.

Attendance	Board Secretary, by invitation any Executive Director, Chair of the Audit Committee to have a right of attendance

Reports to	Board – Annual report on the work of the committee, plus Chair's Summary Assurance report to the Board following each meeting of the committee
Gains assurance from	Executive Leadership Team, Executive Delivery Groups, Executive Management Groups
Sub-Groups	None

Annex 5 - *Audit Committee.*

Designation	WG requirement – Strategic Board Assurance Committee
Purpose	1. Evidenced based and timely advice to the Board and the Accountable Officer on the assurance frameworks to support them in their decision taking and in discharging their accountabilities for securing the achievement of BCUHB's objectives 2. Evidence based assurance to the Board and the Accountable Officer on whether effective arrangements are in place through the operation of the UHB's assurance framework 3. Evidence based assurance to the Board and the Accountable Officer on the effectiveness of Risk Management, Performance Management and other areas as defined by the Board or Accountable officer from time to time
Scope	All activities undertaken, provided or commissioned (clinical and non-clinical) by the Health Board
Membership	4 x Independent Members (one of whom shall be the committee chair)
Attendees	Chief Executive, Director of Finance, (Lead), Executive Director of Nursing and Midwifery/Deputy Chief Executive, Director of Governance, Head of Internal Audit, Local Counter Fraud Specialist, External Auditor.
By invitation	Any Executive Director
Frequency	Quarterly
Reporting Group(s)	(i) Risk Management Group

Annex 6 - *Mental Health & Capacity Compliance Committee.*

Designation	WG requirement – Strategic Board Assurance Committee
Purpose	1. 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) 2. Provide evidence based assurance to the Board that Hospital Managers' duties under the MHA, the functions and processes of discharge under section 23 under the MHA, the provisions laid out in the MCA and the Measure are all exercised in accordance with statute and that there is compliance with the MHA and Code of Practice for Wales and the MCA Code of Practice and the DoLS Code of Practice and the associated regulations
Scope	All services provided to patients with mental health mental health, wherever the setting.
Membership	3 x Independent Members (one of whom shall be the vice-chair of the Board who shall chair this committee)
Attendees	Executive Director of Public Health (Lead), Executive Director of Nursing and Midwifery/Deputy Chief Executive, Executive Director of Primary Care and Community Services, Medical Director for Mental Health, Nurse Director for Mental Health, Director of Mental Health, representatives from Hospital Managers, Service Users, Carers, North Wales Police, Welsh Ambulance Service, IMCA, IMHA, DoLS Manager, MCA Manager.
By invitation	Any Executive Director
Frequency	Bi-monthly
Reporting Group(s)	None

Annex 7 *Charitable Funds Committee.*

Designation	WG requirement – Strategic Board Assurance Committee
Purpose	BCUHB is the Corporate Trustee of its charitable funds and the Board serves as its agent in the administration of the charitable funds held. 1. Evidenced based and timely advice to the Board and the Accountable Officer in the discharge of its duties for Charitable Funds 2. Discharge delegated responsibility from the corporate Trustee for the control and management of Charitable Funds 3. Evidence based assurance to the Board and the Accountable Officer on compliance with Trustee Act 200, The Charities Acts 1993, 1996, 2011 & 2016, and the Terms of the Funds' Governing arrangements
Scope	Administration of all existing charitable funds, fundraising, priorities and spending criteria
Membership	3 x Independent Members (one of whom shall be the committee chair) and Executive Director of Finance (Lead), Executive Director of Planning and Performance, Executive Director of Nursing and Midwifery/Deputy Chief Executive
Attendees	Head of Financial Services, Charitable Funds Accountant, Charitable Funds Fundraising Manager, Investment Advisor
By invitation	Any Executive Director
Frequency	Quarterly
Reporting Group(s)	None

Annex 8 *Remuneration and Terms of Service Committee.*

Designation	WG requirement – Strategic Board Assurance Committee
Purpose	1. Evidenced based and timely 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; 2. Evidence based assurance to the Board and the Accountable Officer 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
Scope	All employment contracts entered into by BCUHB, additional payments (e.g. redundancy, retention), professional registrations
Membership	4 x Independent Members (one of whom shall be the committee chair) and one of whom shall be the Chair of the Audit Committee. A Trade Union Partner Chair of the Local Partnership Forum will attend at meetings held in public as an ex-officio member.
Attendees	Chief Executive, Executive Director of Workforce and Organisational Development (Lead), Executive Medical Director
By invitation	Any Executive Director
Frequency	Quarterly
Reporting Group(s)	None

Annex 9 *Quality, Safety and Experience Committee.*

Designation	WG requirement – Strategic Board Assurance Committee
Purpose	1. Evidence based and timely advice to the Board on quality, safety & experience of Health Services 2. Evidence based and timely advice to the Board on quality, safety & experience of public health, health promotion and health protection 3. Evidence based assurance on safeguarding and improving the quality the quality and safety of patient and citizen centred health 4. Evidenced based assurance to the Board on improving patient, care and citizen experience, including services deliver by partnership 5. Development and oversight of patient related strategies including quality, clinical effectiveness, patient safety and patient experience
Scope	All services provided or commissioned by the Health Board, including acute, community, primary care, and mental health services
Membership	3 x Independent Members (one of whom shall be the committee chair)
Attendees	Executive Director of Nursing and Midwifery/Deputy Chief Executive, Executive Medical Director, Executive Director of Therapies and Health Sciences, Executive Director of Public Health, Executive Director of Primary Care and Community Services, Assistant Director of Patient Safety and Quality, Assistant Director of Patient Experience. Associate Director of Quality Assurance Director of Mental Health & Learning Disabilities. Senior Associate Medical Director. Chair of Healthcare Professionals Forum. Associate Board Member Representative of Community Health Council.
By invitation	A patient representative, a staff representative, Executive Director of Planning and Performance.
Frequency	Bi-monthly
Reporting Group(s)	(i) Executive Delivery Group for Quality Improvement (ii) Clinical Effectiveness Group; (iii) Patient Experience Group; (iv) Patient Safety Group;

	(v) Health and Safety Group

Annex 10 *Performance, Finance and IG Committee.*

Designation	IG is WG requirement other functions BCUHB Discretion – Strategic Board Assurance Committee
Purpose	1. Evidence based and timely advice to the Board on the financial performance of the Health Board and developing the IMTP 2. Evidence based and timely advice to the Board on operational performance of the Hearth Board and associated Impact Improvement Plans 3. Evidence based assurance on the financial position, forecasting, and the capital programme 4. Evidence based assurance to the Board and accountable officer on whether effective arrangements are in place through the operation of the governance framework for data processing and information management 5. Development and oversight of finance and performance related strategies
Scope	All services provided or commissioned by the Health Board, including acute, community, primary care, and mental health services
Membership	3 x Independent Members (one of whom shall be the committee chair)
Attendees	Director of Finance, (Lead), Executive Director of Nursing and Midwifery/Deputy Chief Executive, Executive Director of Planning and Performance, Executive Medical Director, Executive Director of Workforce and OD
By invitation	A patient representative, a staff representative,
Frequency	Bi-monthly
Reporting Group(s)	(i) Capital Investment Group

Annex 11 Partnerships, People and Population Health Committee.

Designation	BCUHB Discretion – Strategic Board Assurance Committee
Purpose	1. Evidence based and timely advice to the Board on our staff and potential staff matters 2. Evidence based and timely advice to the Board on population health outcomes and prevention strategies 3. Evidence based assurance on transformation capacity, delivery and planning 4. Evidenced based assurance to the Board on corporate strategy delivery improving outcomes for citizens, including services deliver by partnership 5. Development and oversight key enabling strategies of people, transformation and digital related strategies
Scope	All services provided or commissioned by the Health Board, including acute, community, primary care, and mental health services
Membership	3 x Independent Members (one of whom shall be the committee chair)
Attendees	Executive Director of Planning and Performance (Lead), Executive Director of Workforce and OD, Executive Medical Director, Executive Director of Nursing and Midwifery/Deputy Chief Executive, Executive Director of Therapies and Health Sciences, Executive Director of Public Health, Executive Director Primary and Community Services .
By invitation	A patient representative, a staff representative, any other Executive Director
Frequency	Bi-monthly
Reporting Group(s)	(i) Population Health Group (including Equalities Forum / Health Improvement Reduce Health Inequalities Group / Primary Care (Health and Care Clusters Group): (ii) Organisational Development Group

Annex 12 *Executive Leadership Team Meeting.*

Designation	BCUHB requirement – Strategic Delivery Group
Purpose	The executive decision making group of the organisation: 1. Ensuring the effective operational co-ordination of all organisational functions, and supporting the Chief Executive to discharge the responsibilities delegated to the Accountable Officer. 2. Provide evidenced based assurance to the Board that there is compliance with 1. The Equalities Act 2010 2. The Human Rights Act 1998 3. The United Nations Convention on the Rights of People with Disabilities 4. BCUHB Policy 3. To provide evidence based advice and assurance concerning all aspects of setting and delivering the strategic direction for the Board, the delivery of its associated strategies, plans the delivery of national requirements and the quality of services, performance and financial management, and associated operational planning and delivery of the Health Board; 4. To support and advise the Board and its Committees in exercising its key functions; 5. To ensure effective operational management of the Health Board, enabling critical issues to be anticipated, discussed, action plans agreed and that there is appropriate integration, connection and liaison between individual services, clinical and corporate functions and between strategic and operational matters; 6. To ensure the organisation remains fit for purpose by continuously reviewing effectiveness and efficiency of the organisational structure and support functions; 7. Oversee and provide evidence based and timely advice to the Executive Leadership Team on relevant Risks including BAF Risks
Attendance	All Executive Directors, the Board Secretary
Reports to	Board
Gains assurance from	Executive Leadership Team members and sub groups
Sub-Groups	(i) Executive Delivery Group - People and Culture,

	(ii) Executive Delivery Group - Transformation & Finance (iii) Executive Delivery Group - Quality Improvement, (iv) Performance Oversight Group, (v) Strategic Health and Safety Group (vi) Risk Management Group

Annex 13 *Commonality – Executive Delivery Groups.*

Designation	BCUHB requirement – Strategic Delivery Group

Purpose	Within the remit of the committee:
	1. **Oversight of delivering the board strategy form current state to future state**
	2. Provide evidenced based assurance to the Executive Leadership Team that there is compliance with
	  1. The Human Rights Act 1998
	  2. The United Nations Convention on the Rights of People with Disabilities
	  3. BCUHB Policy
	3. Provide evidence based and timely advice to the Executive Leadership Team on developing, implementation, monitoring, and impact of relevant sections of the Corporate Strategy
	4. Provide evidence based and timely advice to the Executive Leadership Team on developing, implementation, monitoring, and impact of relevant sub-strategies
	5. Oversee and provide evidence based and timely advice to the Executive Leadership Team on relevant Risks including BAF Risks
	6. Receive the results of relevant audits (clinical and non-clinical) and any other relevant provide the Executive Leadership Team with evidence based impact assessment of the implementation of the recommendations
	7. Approve or endorse relevant policies

Attendance	TBA
Reports to	Executive Leadership Team (ELT) –Chair's Summary Assurance report to ELT following each meeting of the Group
Accountable to	Executive Leadership Team,
Provides evidence	Provide assurance reports to the Board Committees

Annex 14 *Executive Delivery Group People and Culture.*

Designation	BCUHB requirement – Strategic Delivery Group
Purpose	1. Strategy development, implementation, monitoring and evaluation within TOR 2. Development and oversight of Health and Safety, Equality, Education, Organisational Development and resource planning 3. Addressing relevant concerns from the Performance Oversight group in relation to the operational function and performance metrics of the Workforce and OD Directorate 4. Provide evidence based assurance and advice to the Executive Leadership Team to ensure effective governance arrangements are in place to enable the cascade and escalation of issues pertinent to the purpose of this group.
Scope	All services provided or commissioned by the Health Board, including acute, community, primary care, and mental health services
Membership	Executive Director of Workforce and Organisational Development (Chair), 1 other Executive Director, Chair of Each Tactical Sub Group, Senior representatives from Nursing, Medical, Therapies, PH, Finance, Planning
Attendees	TBA
By invitation	A patient representative, a staff representative, any other Executive Director
Frequency	Monthly or 6 weekly
Sub-Groups	(i) Health & Safety (ii) Equalities (iii) Education (iv) Organisational Development (v) resources (vi) Secondary Care (vii) Mental Health (viii) Community & Primary Care

Annex 15 *Executive Delivery Group Transformation & Planning.*

Designation	BCUHB requirement – Strategic Delivery Group
Purpose	1. Strategy development, implementation, monitoring and evaluation within TOR 2. Development and oversight of Transformation Programmes, Planning and Capital 3. Addressing relevant concerns from the Performance Oversight group in relation to the operational function and performance metrics of the Strategy and Planning Directorate 4. Provide evidence based assurance and advice to the Executive Leadership Team to ensure effective governance arrangements are in place to enable the cascade and escalation of issues pertinent to the purpose of this group. 5. Prime responsibility to develop the corporate strategy and IMTP plans 6. Evaluation of the impact of the strategy on public health and prevention 7. Innovation and the Digital Agenda
Scope	All services provided or commissioned by the Health Board, including acute, community, primary care, and mental health services
Membership	Executive Director of Strategy and Planning (Chair), 1 other Executive Director, Chair of Each Tactical Sub Group, Senior representatives from Nursing, Medical, Therapies, PH, Finance, WOD
Attendees	TBA
By invitation	A patient representative, a staff representative, any other Executive Director
Frequency	Monthly or 6 weekly
Sub-Groups	(i) Capital Investment (ii) Transformation Oversight (a) Planned Care) (b) Unscheduled Care (c) Mental Health (iii) Planning Oversight (a) Civil Contingencies (iv) Digital Driver

Annex 16 *Executive Delivery Group Quality Improvement.*

Designation	BCUHB requirement – Strategic Delivery Group
Purpose	1. Strategy development, implementation, monitoring and evaluation within TOR 2. Development and oversight of Clinical Effectiveness, Patient Experience and Patient Safety 3. Addressing relevant concerns from the Performance Oversight group in relation to the operational function & performance metrics of the Nursing, Medical and Therapies Directorates 4. Provide evidence based assurance and advice to the Executive Leadership Team in relation to safeguarding 5. Provide evidence based assurance and advice to the Executive Leadership Team to ensure effective governance arrangements are in place to enable the cascade and escalation of issues pertinent to the purpose of this group.
Scope	All services provided or commissioned by the Health Board, including acute, community, primary care, and mental health services
Membership	Executive Director of Nursing (Chair), Executive Medical Director, Executive Director of Therapies and Health Sciences, Chair of Each Tactical Sub Group, Senior representatives from, PH, Finance, WOD
Attendees	TBA
By invitation	A patient representative, a staff representative, any other Executive Director
Frequency	Monthly or 6 weekly
Sub-Groups	(i) Patient Experience (ii) Clinical Effectiveness (iii) Patient Experience

Annex 17 *Executive Delivery Group Financial Sustainability.*

Designation	BCUHB requirement – Strategic Delivery Group
Purpose	1. Strategy development, implementation, monitoring and evaluation within TOR 2. Development and oversight of financial sustainability and programmes 3. Addressing relevant concerns from the Performance Oversight group in relation to the operational function & performance metrics of Finance Directorate 4. Provide evidence based assurance and advice to the Executive Leadership Team in relation to financial probity 5. Provide evidence based assurance and advice to the Executive Leadership Team to ensure effective governance arrangements are in place to enable the cascade and escalation of issues pertinent to the purpose of this group.
Scope	All services provided or commissioned by the Health Board, including acute, community, primary care, and mental health services
Membership	Executive Finance (Chair), 1 other Executive Director, Chair of Each Tactical Sub Group, Senior representatives from Nursing, Medical, Therapies, PH, Planning, WOD
Attendees	TBA
By invitation	A patient representative, a staff representative, any other Executive Director
Frequency	Monthly or 6 weekly
Sub-Groups	(i) Programme Management

Annexes 18-20 Draft Cycles of Business

Annex 18 - DRAFT Performance, Finance and Information Governance CYCLE OF BUSINESS / Information flow.

Also meets in January and March specifically to consider the annual plan.

Agenda item	Apr	Jun	Aug	Oct	Dec	Feb
Governance						
Apologies	✓	✓	✓	✓	✓	✓
Declaration of Interests	✓	✓	✓	✓	✓	✓
Minutes from previous meeting	✓	✓	✓	✓	✓	✓
Matters Arising & Action Log	✓	✓	✓	✓	✓	✓
Report of the Chair • Chair's Action • **Feedback from the Board**	✓ ✓ ✓	✓ ✓ ✓	✓ ✓ ✓	✓ ✓ ✓	✓ ✓ ✓	✓ ✓ ✓
Report of the Lead Executive	✓	✓	✓	✓	✓	✓
Notification of Matters referred from other Board Committees on this or future agendas	#	#	#	#	#	#
Strategic Items for Decision – The Future						
Developing New Strategies or Plans						
Annual Financial Plan	ToR					✓
Corporate Strategy - Financial						
Tier 1 Strategies for Board Approval – to be defined in the corporate strategy (Living Healthier, Staying Well) • Financial aspects of corporate strategy • Financial Aspects of IMTP • Financial / Sustainability Strategy • Information Governance Strategy						✓
Tier 2 Strategies for committee approval – to be defined in the corporate strategy (Living Healthier, Staying Well) • Estates • Environmental • Performance Management Framework • Decarbonisation Strategy				✓	✓ ✓ ✓	
Monitoring Existing Strategies or plans						
Corporate Strategy (Financial Monitoring Report)						
Monitoring Tier 1 Strategies on behalf of the Board – as defined in the corporate strategy • Financial aspects of corporate strategy					✓	

Agenda item	Apr	Jun	Aug	Oct	Dec	Feb
• Financial Aspects of IMTP • Financial / Sustainability Strategy • Information Governance Strategy						
Monitoring Tier 2 Strategies for committee approval – as defined in the corporate strategy) • Estates • Environmental • Performance Management Framework • De-carbonisation Strategy	✓			✓	✓ ✓ ✓	
Other						
Endorse relevant policies reserved for Board approval	#	#	#	#	#	#
Agree relevant polices reserved for committee approval	#	#	#	#	#	#
Standing Financial Instructions / Standing Orders						✓
Annual Capital Programme	✓					
Transforming Services - Outcomes • Mental Health • Planned Care • Primary and Community Care • Unscheduled Care	✓ ✓	 ✓ ✓	✓ ✓	 ✓ ✓	✓ ✓	 ✓ ✓
Recommendations from the Primary Care Panel to take on new GP practices	#	#	#	#	#	#
Quality Safety and Performance – The Present (for Assurance)						
Board Assurance Framework		✓			✓	
Corporate Risk Register		✓			✓	
Finance Report (including workforce cost report)						
Divisional Operational Finance Reports • Finance • Mental Health • Primary and Community Care (including Therapies) • Public Health • Secondary Care (including North Wales Managed Services) • • Strategy and Planning • Women's and Children's • Workforce and OD	✓ ✓ ✓	 ✓ ✓ ✓	 ✓ ✓ ✓	✓ ✓ ✓	 ✓ ✓ ✓	 ✓ ✓ ✓

Agenda item	Apr	Jun	Aug	Oct	Dec	Feb
Integrated Performance Report (incorporating seeing services from the front line) • Finance • Performance	✓	✓	✓	✓	✓	✓
Report from Performance Oversight Group	✓	✓	✓	✓	✓	✓
Financial Planning process						✓
Capital Programme Monitoring Report			✓			✓
External Contracts Assurance Report	✓			✓		
Shared Services Partnership Assurance Report		✓			✓	
Assurance reports on Particular Areas of Concern – time limited	#	#	#	#	#	#
Welsh Government Monthly Monitoring Return	✓	✓	✓	✓	✓	✓
Capital and Estates Business Cases	#	#	#	#	#	#
Benefits Realisation Gateway Reviews	#	#	#	#	#	#
Medical Locum Doctors including Junior Doctors rota, medical and dental agency locums report	#	#	#	#	#	#
Learning from – The Past						
Independent Assurance Reviews	#	#	#	#	#	#
Internal Assurance Reviews	#	#	#	#	#	#
Relevant Ombudsman reports	#	#	#	#	#	#
Chairs' Assurance Reports / Lead Executive Triple A Report						
Chairs' Assurance Reports (for assurance) • Executive Delivery Group – Transformation and Finance • Capital Investment Group • Performance Oversight Group	✓	✓	✓	✓	✓	✓
Chairs' Assurance Reports (for information) • Executive Delivery Group – People and Culture • Executive Delivery Group - Quality Improvement	✓	✓	✓	✓	✓	✓
Other						
Annual Work plan						✓
						✓
						✓
Closing Business						

Agenda item	Apr	Jun	Aug	Oct	Dec	Feb
Agree Items for referral to Board / Other committees	✓	✓	✓	✓	✓	✓
Review of Risks highlighted in the meeting for referral to Risk Management Group	✓	✓	✓	✓	✓	✓
Agree items for Chairs' Assurance Report	✓	✓	✓	✓	✓	✓
Review of Meeting Effectiveness	✓	✓	✓	✓	✓	✓

Annex 19 DRAFT PPPH CYCLE OF BUSINESS / Information flow.

Agenda item	Apr	June	Aug	Oct	Dec	Feb
Opening Business						
Staff Story	✓	✓	✓	✓	✓	✓
Apologies	✓	✓	✓	✓	✓	✓
Declaration of Interests	✓	✓	✓	✓	✓	✓
Minutes from previous meeting	✓	✓	✓	✓	✓	✓
Matters Arising & Action Log	✓	✓	✓	✓	✓	✓
Report of the Chair • Chair's Action • **Feedback from the Board**	✓ ✓ ✓	✓ ✓ ✓	✓ ✓ ✓	✓ ✓ ✓	✓ ✓ ✓	✓ ✓ ✓
Report of the Lead Executive	✓	✓	✓	✓	✓	✓
Notification of Matters referred from other Board Committees on this or future agendas	#	#	#	#	#	#
Strategic Items for Decision – The Future						
Developing New Strategies or Plans						
Corporate Strategy	✓	✓				
Tier 1 Strategies for Board Approval – to be defined in the corporate strategy (Living Healthier, Staying Well) • IMTP • Transformation (TBC) • Digital • Partnership (TBC) • Organisational Development	✓	✓	✓ ✓ ✓	✓		
Tier 2 Strategies for committee approval – to be defined in the corporate strategy (Living Healthier, Staying Well) • Recruitment and Retention (TBC) • Equalities • Third sector engagement strategy (TBC)					✓	
Monitoring Existing Strategies or plans						
Monitoring Tier 1 Strategies on behalf of the Board – as defined in the corporate strategy) • IMTP • Transformation • Digital • Partnership • Organisational Development	✓ ✓	✓	✓ ✓ ✓	✓ ✓	✓	✓ ✓ ✓
Monitoring Tier 2 Strategies for committee approval – as defined in the corporate strategy) • Recruitment and Retention	✓	✓		✓	✓	

Agenda item	Apr	June	Aug	Oct	Dec	Feb
• Equalities						
Other						
Endorse relevant policies reserved for Board approval	#	#	#	#	#	#
Agree relevant polices reserved for committee approval	#	#	#	#	#	#
Policy status update including relevant policies reserved for Executive approval			✓			✓
Staff Survey						
Winter Plan			✓	✓		
Major Incident Plan / Civil Contingencies Act		✓			✓	
Regional Partnership Board	✓			✓		
Partners Strategy Presentations	#	#	#	#	#	#
Quality Safety and Performance – The Present						
Board Assurance Framework related to committee	✓			✓		
Corporate Risk Register	✓			✓		
Directorate Operational Reports (incorporating seeing services from the front line) • **Public Health (Including Adverse Child Experience, Smoking Cessation, Healthy Lives, Well North Wales Inequalities, Alcohol Use, Vulnerable Groups)** • **Workforce and OD** • **Strategy and Planning** • **Population Health (including Primary Care Clusters, Health Inequalities, and Public Sector Equality Duty)**	✓	✓ ✓	✓	✓	✓ ✓	✓
Assurance reports on Particular Areas of Concern – time limited	#	#	#	#	#	#
Staff Survey and quarterly Pulse Reports		✓	✓		✓	✓
Workforce Report		✓			✓	
Population Health Report			✓			✓
Freedom to Speak Up Guardian Report	✓			✓		
Corporate Health at Work	✓			✓		
IMTP - Annual Plan and compliance with the Wellbeing of Future Generations (Wales) Act (2015)		✓			✓	✓
Welsh Language			✓			✓
Partnership Governance Arrangements	✓			✓		

Agenda item	Apr	June	Aug	Oct	Dec	Feb
Test and Trace Programme Update (short life)	✓	✓	✓	✓	✓	✓
Consultations and Engagement Outcomes Report		✓			✓	
Annual Reports						
Committee Annual Report to Audit Committee	✓					
Review Committee Terms of Reference	✓					
Community Health Council Annual Report		✓				
Equality Annual Report		✓				
Workforce Annual Report		✓				
Learning from – The Past						
Independent Assurance Reviews	#	#	#	#	#	#
Internal Assurance Reviews	#	#	#	#	#	#
Public Ombudsman reports	#	#	#	#	#	#
Chairs' Assurance Reports / Lead Executive Triple A Report						
Chairs' Assurance Reports from Strategic and Tactical Delivery Groups (for assurance) • Executive Delivery Group – People and Culture • Executive Delivery Group – Transformation and Finance • Population Health Group • Capital Investment Group	✓ ✓ ✓ ✓	✓ ✓ ✓ ✓	✓ ✓ ✓ ✓	✓ ✓ ✓ ✓	✓ ✓ ✓ ✓	✓ ✓ ✓ ✓
Chairs' Assurance Reports (for information) • Executive Delivery Group - Quality Improvement	✓	✓	✓	✓	✓	✓
Partnership Meetings • Regional Partnership Board • Public Service Board – Gwynedd and Anglesey • Public Service Board – Flintshire • Public Service Board – Wrexham and Denbighshire • Public Service Board – Conwy • Together for Mental Health Partnership Board • Mid Wales Collaborative Agreement	✓ ✓ ✓	 ✓ ✓	 ✓ ✓ ✓	✓ ✓ ✓	 ✓ ✓	 ✓ ✓ ✓
Other						

Agenda item	Apr	June	Aug	Oct	Dec	Feb
Closing Business						
Agree Items for referral to Board / Other committees	✓	✓	✓	✓	✓	✓
Review of Risks highlighted in the meeting for referral to Risk Management Group	✓	✓	✓	✓	✓	✓
Agree items for Chairs' Assurance Report	✓	✓	✓	✓	✓	✓
Review of Meeting Effectiveness	✓	✓	✓	✓	✓	✓

Annex 20 DRAFT Quality, Safety and Experience Committee CYCLE OF BUSINESS / Information flow.

Agenda item	Mar	May	Jul	Sep	Nov	Jan
Opening Business						
Patient/Staff Story	✓	✓	✓	✓	✓	✓
Apologies	✓	✓	✓	✓	✓	✓
Declaration of Interests	✓	✓	✓	✓	✓	✓
Minutes from previous meeting	✓	✓	✓	✓	✓	✓
Matters Arising & Action Log	✓	✓	✓	✓	✓	✓
Report of the Chair • Chair's Action • **Feedback from the Board**	✓ ✓ ✓	✓ ✓ ✓	✓ ✓ ✓	✓ ✓ ✓	✓ ✓ ✓	✓ ✓ ✓
Report of the Lead Executive	✓	✓	✓	✓	✓	✓
Notification of Matters referred from other Board Committees on this or future agendas	#	#	#	#	#	#
Strategic Items for Decision – The Future						
Developing New Strategies or Plans						
Quality Elements of the Corporate Plan		✓	✓	✓		
Tier 1 Strategies for Board – to be defined in the corporate strategy (Living Healthier, Staying Well) • Quality Improvement Strategy • Clinical Strategy • Engagement Strategy • Health and Safety Strategy			✓ ✓	 ✓ ✓		
Tier 2 Strategies for committee approval – to be defined in the corporate strategy (Living Healthier, Staying Well) • Patient Experience Strategy • Safeguarding Strategy • Carers Strategy • Dementia Strategy • Mental Health Strategy		 ✓	 ✓	✓ ✓ ✓		
Agree Quality aspects of IMTP • Agree Annual Quality Plan - The Health and Social Care (Quality Engagement) (Wales) Act	✓ ✓					
Monitoring Existing Strategies or plans						
Corporate Strategy (Quality Monitoring Report)	Board		✓			✓
Quality aspects of IMTP • Annual Plan		✓ ✓		✓ ✓		✓ ✓

Agenda item	Mar	May	Jul	Sep	Nov	Jan
Monitoring Tier 1 Strategies on behalf of the Board – as defined in the corporate strategy) • Quality Improvement Strategy • Clinical Strategy • Engagement Strategy • Health and Safety Strategy	 ✓ ✓		✓ ✓	 ✓ ✓		✓ ✓
Monitoring Tier 2 Strategies for committee Approval – as defined in the corporate strategy) • Patient Experience Strategy • Safeguarding Strategy • Carers Strategy • Dementia Strategy • Mental Health Strategy	 ✓ ✓ ✓	 ✓	 ✓	 ✓ ✓ ✓	 ✓	 ✓
Other						
Endorse Quality Policies reserved for Board approval	#	#	#	#	#	#
Agree Quality Polices reserved for QSE approval	#	#	#	#	#	#
Policy status update including policies relevant reserved for Executive approval			✓			✓
Quality Safety and Performance – The Present						
Board Assurance Framework (relevant to QSE)		✓			✓	
Corporate Risk Register (relevant to QSE)	✓	✓	✓	✓	✓	✓
Directorate Operational Reports (incorporating seeing services from the front line) • **Mental Health** • **Primary and Community Care (including Continuing Health Care & Therapies)** • **Public Health** • **Secondary Care (Including North Wales Managed Services)** • **Women's and Children's**	 ✓ ✓	 ✓ ✓	 ✓ ✓	 ✓ ✓	 ✓ ✓	 ✓ ✓
Integrated Performance Report (incorporating seeing services from the front line) • Quality (including numbers of incidents)	✓	✓	✓	✓	✓	✓
Deep Dive reports • **Clinical Effectiveness (including Clinical Audit)**	✓		✓		✓	

Agenda item	Mar	May	Jul	Sep	Nov	Jan
• **Patient Safety (including learning from incidents)**	✓		✓		✓	
• **Patient Experience**		✓		✓		✓
• **Health and Safety**		✓		✓		✓
• **Safer Staffing**		✓			✓	
Quality in partner or commissioned services • Welsh Health Specialised Services • Welsh Ambulance Services • Care Homes		✓		✓		✓
Prevention • Annual Flu planning and implementation • Immunisation report	✓ ✓			✓ ✓		
Assurance reports on Particular Areas of Concern – time limited	#	#	#	#	#	#
Annual Reports						
Committee Annual Report to Audit Committee	✓					
Review Committee Terms of Reference	✓					
Quality Annual Report		✓				
Putting things Right Annual Report		✓				
Safeguarding Annual Report			✓			
Infection Prevention and Control Annual Report			✓			
Accessible Healthcare Annual Report				✓		
Radiation Protection Annual Report				✓		
Tissue and Organ Donation Annual Report				✓		
Learning from – The Past						
Independent Assurance Reviews	#	#	#	#	#	#
Internal Assurance Reviews	#	#	#	#	#	#
Quality Improvement Team Annual Report	#	#	#	#	#	#
Health Inspectorate Wales Reports	#	#	#	#	#	#
Health Inspectorate Wales Annual BCU report			✓			
Public Ombudsman reports	#	#	#	#	#	#
Chairs' Assurance Reports						
Chairs' Assurance Reports from Strategic and Tactical Delivery Groups (for assurance)	✓	✓	✓	✓	✓	✓
• Executive Delivery Group - Quality Improvement	✓	✓	✓	✓	✓	✓

Agenda item	Mar	May	Jul	Sep	Nov	Jan
• Patient Safety • Clinical Effectiveness Group • Health and Safety Group • Patient Experience Group	✓ ✓ ✓	✓ ✓ ✓	✓ ✓ ✓	✓ ✓ ✓	✓ ✓ ✓	✓ ✓ ✓
Chairs' Assurance Reports (for information) • Executive Delivery Group – Transformation and Finance • Executive Delivery Group – People and Culture	✓ ✓	✓ ✓	✓ ✓	✓ ✓	✓ ✓	✓ ✓
Partnership meetings (for information) • Regional Partnership Board		✓			✓	
Advisory Groups (for information) • Health Care Professionals Forum • Local Partnership Forum • Stakeholder Reference Group	✓	✓	✓	✓	✓	✓
Other						
Closing Business						
Agree Items for referral to Board / Other committees	✓	✓	✓	✓	✓	✓
Review of Risks highlighted in the meeting for referral to Risk Management Group	✓	✓	✓	✓	✓	✓
Agree items for Chairs' Assurance Report	✓	✓	✓	✓	✓	✓
Review of Meeting Effectiveness	✓	✓	✓	✓	✓	✓

Proposed Integrated Governance Framework
2020

Simon Evans-Evans

v1.~~11~~14

Contents

1. Rationale

1.1. Background

The Welsh Government placed the Health Board into Special Measures on 8 June 2015 with the intention that we would be able to demonstrate progress and move down through the four 'escalation' levels:

- Special measures.
- Targeted intervention.
- Enhanced monitoring.
- Routine arrangements.

In May 2019, maternity services and GP out-of-hours were taken out of Special Measures and on 24 November 2020, following advice and recommendation from the tripartite meeting of NHS Wales, Audit Wales and Healthcare Inspectorate Wales the Welsh Government stepped the Health Board down from 'Special Measures' to 'Targeted Intervention'.

During Special Measures and Targeted Intervention, the Welsh Government has highlighted Governance as an area that the Health Board needs to improve.

1.2. Findings

In this review process during a series of one to one interviews, board members raised a number of concerns including, but not limited to:

- Lack of sight from the Board through the organisation to the front line.
- Too much board and committee time focused on detailed operational matters.
- Not enough time at board and committee to focus on developing strategies.
- Lack of clear building blocks for governance (corporate strategy, performance management, road map out of special measures, prioritised medium and long term planning).
- Holding execs to account is important, but developing strategy and culture is more important and is missing.
- No co-ordinated oversight from the Board in relation to "our greatest asset" – our people.
- No visibility from the Independent Members in the operational support structure to give assurance against statements made by Executives.
- Lack of confidence from the Independent Members that Executives are delivering what has been agreed.
- Visibility of Executives through the organisation.
- Inadequate individual performance management.
- The board has two groupings (Independent Members and Executive Directors), is not acting as a unitary Board and there is a lack of trust.
- Lack of a patient focus at Board level.
- Committees need clear structure and process to allow a balance of day to day versus strategic.

- Inadequate links between Board and organisational governance.
- Too much time spent on governance and oversight on writing reports and presentations.
- Too many meetings that Independent Members are required to attend.
- Board and committee meetings are too long and less productive towards the end.
- Poor information flow, inadequate use of information, data and analytics.
- No performance culture and lacking in consequence poor reporting culture.
- Need more transformational leadership and succession planning.

1.3. Governance outcomes within the Targeted Intervention Improvement Framework (TIIF)

The TIIF sets out outcomes the Welsh Government expect to see and reflects some of the comments made by Board Members and highlighted in section 1.2.

The TIIF states that the Health Board will need to agree its own approaches to the development and implementation of the matrices; however, as a guide the following section sets out the themes and challenges that the Welsh Government expects to be addressed. The overriding expectation of the framework is to ensure that:

- Ongoing transformation, improvement and innovation leads to improved trajectory of outcomes, patient experience and financial performance year on year.
- A revised accountability and performance framework delivers improvements in performance and patient safety.
- The health board builds on relationships and existing partnership structures and fully engages and involves the public, staff, trade unions and partners on the transformation and reshaping of services.
- A sustainable vision for the future is agreed and communicated to the public, staff, trade unions and partners.
- The development of a medium term plan, incorporating a robust three-year financial plan to meet its financial duties.
- The development and implementation of a long term integrated clinical services strategy.
- Strengthen leadership capacity and enhanced governance supports organisational development, decision making and resilience.
- Improvements will be celebrated, leading to de-escalation, as assessed by the maturity matrix approach.

The specific Governance and Leadership outcomes are indicative of the building blocks that need to be reflected in the transformation journey.

- Develop and embed a compelling vision for the Health Board that is understood, recognised and accepted throughout the organisation.
- Demonstrate visible clinical leadership engaging patients, partners and staff.

- An effective, integrated Board setting a clear strategic direction for the organisation.
- An open and transparent culture and willingness to learn.
- Consolidation of executive leadership supported by a development programme for the Executive Team.
- Collective responsibility for quality and patient safety across the executive team and clearly defined roles for professional leads.
- A revised accountability and performance framework, underpinned by a robust governance structure.
- Visibility and oversight of clinical audit and improvement activities across divisions/groups/directorates and at corporate level.
- A strong approach to organisational learning supported by a culture of high quality care.

1.4. What is the Integrated Governance Framework trying to achieve?

Organisational governance, culture and behaviour are inextricably linked. Colloquially governance can be described as “the way we do things around here”; culture can be described as “the way we do things around here – when no-one is watching”. The proposed framework therefore needs to be supported by the Organisational Development Programme to address the behavioural and cultural issues raised by Board Members and the Welsh Government.

The framework also needs to align to the emerging corporate strategy, as the framework is the delivery and assurance structure for the strategy.

The framework aims to support the Board in its key functions of leading the Health Board to be effective and to deliver the principal role of a Health Board:

To ensure the effective planning and delivery of healthcare for people for whom it is responsible, within a robust governance framework, to achieve the highest standards of patient safety and public service delivery, improve health, reduce inequalities and achieve the best possible outcomes for its citizens, and in a manner that promotes human rights.

1.5. What are the objectives?

The governance proposals are designed to meet the follow objectives agreed by the Board:

Objective 1:

- Ensure that the work of the Board and committees are pitched at the right level and balance their responsibilities in strategy, culture and accountability.

Objective 2:

- Develop a greater focus on strategy in committee – delivering for the future.

Objective 3:

- Improve the focus, co-ordination and relevance of Board and committee papers with built in assurance levels.

Objective 4:

- Give the Board clear line of sight over business as usual and strategic delivery structures, including lines of accountability to provide better assurance and reduce duplication.

Objective 5:

- Develop greater oversight of the People / Transformation agenda.

Objective 6:

- Improve information flow: no orphan groups - improve the line of sight from Floor to Board through increased governance discipline.

2. The Integrated Governance Framework

2.1. What is the Integrated Governance Framework?

The Integrated Governance Framework sets out the means by which the Board and staff ensure that they are doing the right things, in the right way, for the right people, in a manner that upholds the values set for the Welsh public sector.

2.2. What do we mean by Integrated Governance?

Integrated governance can be defined as:

'Systems and processes by which we lead, direct and control our functions in order to achieve organisational objectives, safety, and quality of services, and in which we relate to the wider community and partner organisations.'

For the Board (and the organisation) to be effective, it has to be assured that integrated governance systems are closely intertwined. Each decision has to focus closely on the requirements of the different aspects of governance, in particular five governance arrangements collectively known as Integrated Governance or as a system just Governance:

- Clinical governance.
- Corporate governance.
- Research governance.
- Information governance.
- Financial governance.

The main features of an integrated governance model are:

- Integrating risk assessment with the initial objective setting.
- Developing a process for reporting progress against objectives.

- Aligning the various governance systems so that they complement each other without overlap.
- Developing an effective assurance framework.
- Ensure the committee structure is fit for purpose.

Governance provides a focus on:

- Vision.
- Strategy.
- Leadership.
- Assurance.
- Probity.
- Stewardship.

2.3. What is the purpose of Integrated Governance Framework?

Integrated Governance is the system that allows the Health Board and the Board to ensure the Health Board delivers its core purpose, namely:

- Effective planning and delivery of healthcare for people for whom it is responsible.
- A robust governance framework.
- Achievement of the highest standards of patient safety and public service delivery.
- Improve health.
- Reduce inequalities.
- Achieve the best possible outcomes for its citizens.
- Promote human rights.

Our Board is an Integrated Board which functions as a corporate decision making body. Executive Directors and Independent Members are full members and share corporate responsibility for all the decisions of the Board. However, for committees with a primary scrutiny function, membership is limited to Independent Members, with Executive Directors in attendance:

The three key roles through which effective Integrated Boards demonstrate leadership are:

- Formulating strategy.
- Ensuring accountability by holding the organisation to account for the delivery of the strategy and through seeking assurance that systems of control are robust and reliable.
- Shaping a positive culture for the Board and the organisation.

Key Board Role	Independent Members' role	Executive Directors' role
Formulating Strategy	Joint Responsibility	Joint Responsibility
Ensure Accountability and Delivery	Support and Assurance	Delivery and Assurance
Shape Culture	Joint Responsibility	Joint Responsibility

2.4. What is assurance?

Academi Wales describes assurance as:

Providing: 'Confidence' / 'Evidence' / 'Certainty'.
To: Directors / Non-executives / Management.
That: What needs to be happening is actually happening in practice.

NHS Boards may seek and receive assurance from a wide range of sources within their organisation, both directly and through the operation of its committees, notably those responsible for Audit and for Quality & Safety. The key challenge for Boards is understanding each link in the assurance chain, what part it plays in the overall framework of assurance, and the value they should place on it. The Audit Commission (2009b) describes an approach to internal assurance as a "three lines of defence" assurance model:

First line of defence: Responsibility lies with healthcare staff and teams working at the 'frontline' to understand their roles and responsibilities and to carry them out properly and thoroughly. If working practices (the 'systems and processes') are well designed, and staff are equipped to follow them, compliance with the arrangements should mean risks in day-to-day activities are routinely managed.

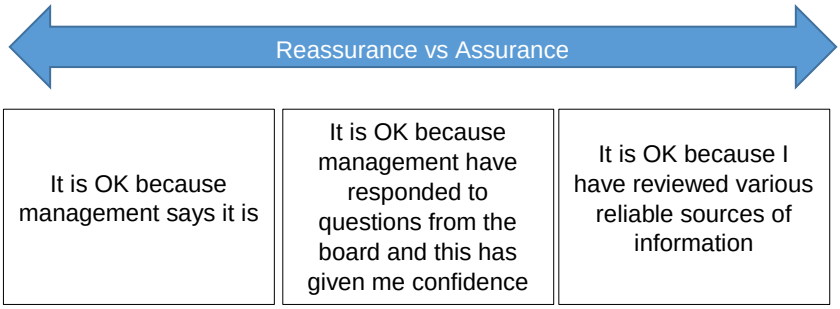
Second line of defence: This typically comprises executive/management arrangements established to ensure compliance with the standards, policies and working practices set through active oversight of the operation of the first line of defence. Typically, this includes holding them to account for the effectiveness of their activities, and may include routine assessment, inspection and review activity to ensure the achievement of standards and compliance with policies and procedures.

Third line of defence: This is independent review, designed to assess the overall adequacy and effectiveness of the first and second lines of defence. The key source of this 'independent' assurance is through functions such as internal audit, although there are other sources of independent review that can also be used, including inspectorates and review bodies. (Academi Wales)

NOTE: The Board Assurance Framework defines the levels of assurance on controls as

0 – Policies in place but not actively managed
1 – 1st Line: Department.
2 – 2nd Line: Organisational.
3 – 3rd Line: Independent.

The three lines of defence are sometimes referred to as the reassurance versus assurance continuum:



2.5. What are the principles in this Integrated Governance Framework?

- Set clarity for the Board and staff within the Health Board in relation to:
  - Assurance.
  - Accountability.
  - Decision making and approval.
  - Roles and Responsibilities.
  - Effective segregation of duties.
- Have clear alignment to:
  - The Health Board's principle role and purpose.
  - Welsh Government expectations.
  - Targeted Intervention Improvement Framework.
  - Health Inspectorate Wales expectations.
- Provide a model that aligns to:
  - Quality management (Patient experience, Patient safety and Clinical effectiveness).
  - Innovation, learning and modelling new ways of working.
  - Risk Management and Board Assurance Framework.
  - Performance and Accountability Framework.
  - Strategy delivery.
  - People management.
  - Financial management.
  - Data management.
  - Process and policy development.

2.6. Framework design

To aid clarity of purpose in groups and committees. The model is intended to provide transparency on where and how we obtain assurance, responsibility for delivery, it takes into account the wider health systems and requirements in Wales and aligns wider governance structures (as listed above). The framework also

guides groups as to their purpose in the Health Board, Assurance or Delivery, Strategic, Tactical or Operational.

The proposed BCUHB model has the Integrated Board supported in its assurance and culture setting roles by good and solid **Process Management** (including Risk, quality systems, Equality Impact Assessments to assure the promotion of human rights etc.). Good **Performance Management** (helping to give sight from floor to Board and to see outcomes) and a co-ordinated focus on **prevention**.

It is supported in is strategic and culture setting roles by focusing on 4 domains;

- **Population Health** (improving health, reducing inequalities).
- **Patients** (best possible outcomes).
- Our **People** (not just well-being and recruitment, but planning for the future, education enabling the organisation to deliver on a Transformation programme etc.).
- Finances **(Pounds).**

All of the above is evidenced or enabled by the **Operational Delivery, Digital Enabler, Learning Innovation and Best Practice** and by **Working in Partnership**

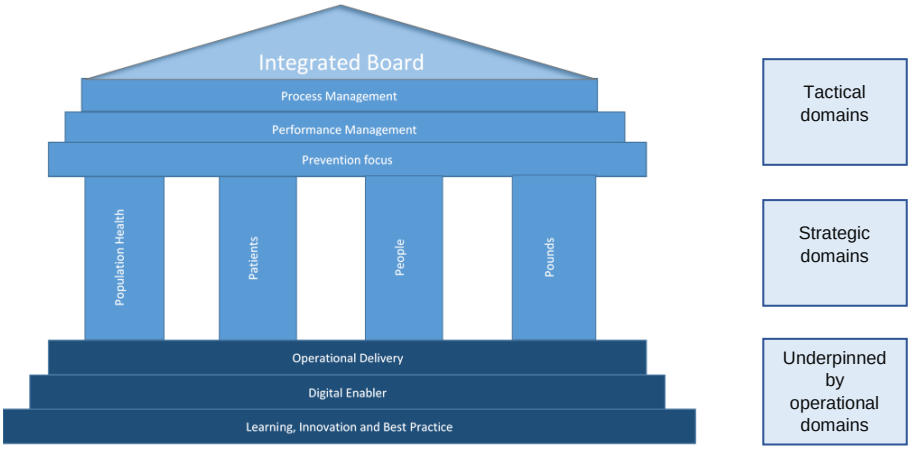


Figure 1 : The Betsi Model of Governance

3. The Integrated Governance Framework in practice

The Good Governance Guide for NHS Wales is clear where independent Members and Executive Directors have joint endeavour and where they have different roles. Board committees are formed to support the Board develop strategy, set culture and hold the Executive arm of the Board to account for delivery.

The Board as a whole is responsible for the WHAT and the Executive for the HOW. The Integrated Board agrees and sets the vision, goals and priorities and the executive develop the strategies to deliver them. We can define strategy as "the high level blueprint that articulates the vision and sets key milestones and measures of success". Once the strategies are approved, the Executive then develop the detailed plans for delivery and the Board measures and monitors progress and performance against the plan.

3.1. Board Structure

3.1.1. Purpose of Board committees

Board Committees are charged with supporting the Board to deliver on its purpose by:

- Setting and embedding culture.
- Developing and monitoring strategy.
- Holding the Executive Leadership to account for delivery (both operational delivery and strategic delivery).

Therefore, Board Committees can only have membership drawn from the Independent Members so as not to conflict Executive Members of the Board.

3.1.2. Board committee structure

The Board has three joint committees with other health boards in Wales to support pan Wales delivery and three advisory Groups as laid out in regulation, other Board committees are at the discretion of the Board (provided that certain functions are fulfilled[1]). In this model, all committees have a duty to support the Board in setting the culture of the organisation. There are:

- Three committees primarily focused on proving assurance and supporting the organisational culture within a relatively narrow remit.
  - Mental Health Compliance and Capacity Committee (MHCC).
  - Remuneration and Terms of Service Committee (RaTS).
  - ~~Charity~~Charitable Funds Committee (CC).
- Three committees primarily focused on strategy development & monitoring, supporting organisational culture and assurance. These committees also reflect the four strategic domains in the governance model (Patients, Pounds, People and Population Health).
  - Quality, Safety and Experience (QSE).
  - Performance, Finance and Information Governance (PFIG).
  - Partnerships, People and Population Health (PPPH).
- Audit Committee (AC) to review governance and assurance processes critically on which the Board places reliance.

[1] Oversight of: Audit; Quality and Safety; Information Governance; Charitable Funds; Remuneration and Terms of service; Mental Health Act Compliance

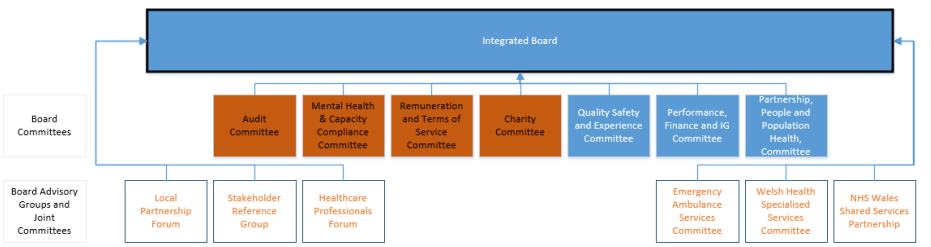


Figure 2 - Betsi Board and committee structure

3.1.3. Segregation of responsibilities

Whilst all members of the Board have joint responsibilities and all Board committees have joint responsibility in relation to setting and embedding culture and in ensuring organisational compliance and assurance, responsibilities are segregated to allow for effective check, challenge and assurance in relation to strategic and operational delivery. This ensures that Independent Members remain independent of operational matters and Executive Directors can be held to account for organisational performance. Figure 3 demonstrates the relevant roles and responsibilities of Board Committees and the Executive Leadership Team.

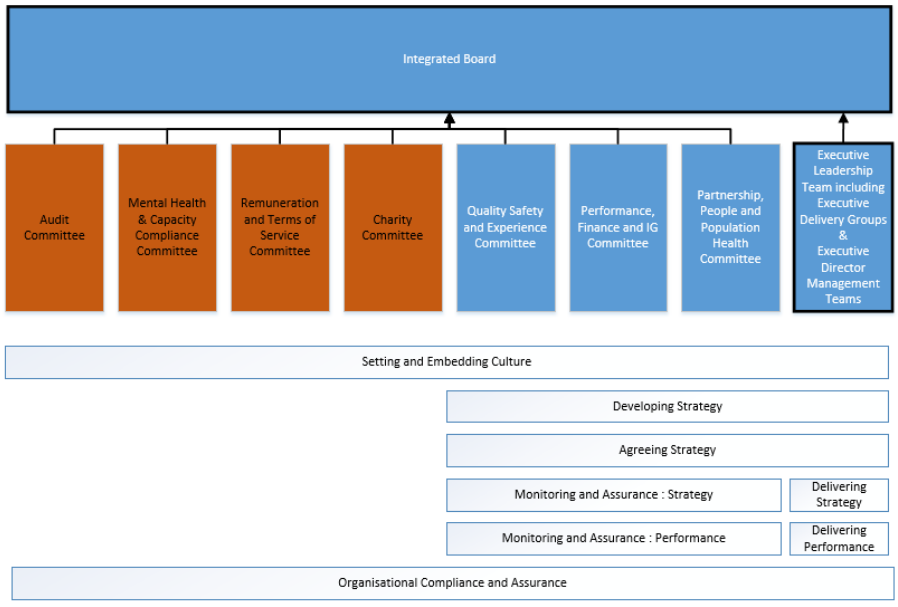


Figure 3 - Segregation of responsibility

3.1.4. What is different from the current model?

Current Committee	New Committee	Changes
Audit	Audit	No Change
Mental Health Act	Mental Health & Capacity Compliance	Focus on compliance with the Mental Health Act Removed mental health divisional quality assurance to 'mainstream' quality of mental health services and provision within the QSE
Power of Discharge Sub-committee	None	Changed form a formal sub-committee to a Power of Discharge Group for Hospital Managers reporting to MHCC Committee quarterly *(in line with CAVUHB)*
Remuneration and Terms of Service	Remuneration and Terms of Service	No change
Charitable Funds	~~Charity~~None	~~Name change only~~No Change
Digital and Information Governance	None	Digital agenda moved to PHPP as an enabling strategy (although alignment of enabling strategies already in Strategy, Partnerships, Population Health Committee ToR) IG moved to PFIG
Quality, Safety and Experience	Quality, Safety and Experience	Wider focus to include quality of MH and primary care services, and quality related strategies
Finance and Performance	Performance, Finance and IG	Removed people agenda, focus to include IG and PFIG related strategies
Strategy Partnerships and Population Health	Partnerships, People and Population Health	removed Quality and Finance strategies, focus to include people and enabling strategies
Board Advisory Groups and Joint Committees		No Change

Other changes

- ~~At the request of the committee change of name from Charitable Funds Committee to Charity Committee.~~

- Chair and Chair of the Audit Committee to have right to attend all committees for assurance purposes.
- Reduce the frequency of the Board Secretary led Chairs business meetings to twice yearly.

The Board uses a committee structure to support its work.

The Executive Leadership Team is the delivery arm of the integrated Board responsible for delivering business as usual and strategy. Board committees are supported by Executive Delivery Groups (to delivery Strategy) and Executive Management Groups (to deliver operational performance). In turn, these are supported by Tactical Delivery Groups that will provide assurance reports to committees and undertake some of the detailed work for the committee; they will review and produce evidence to enable the Board committee to focus on its priorities during meetings. Tactical Delivery Groups will also be able to undertake and evaluate research to support the board develop strategies.

Figure 4 shows these groups and the assurance & information flows (in tan dotted lines) and reporting lines (in black lines). (See annexes 1-3 for individual committee details)

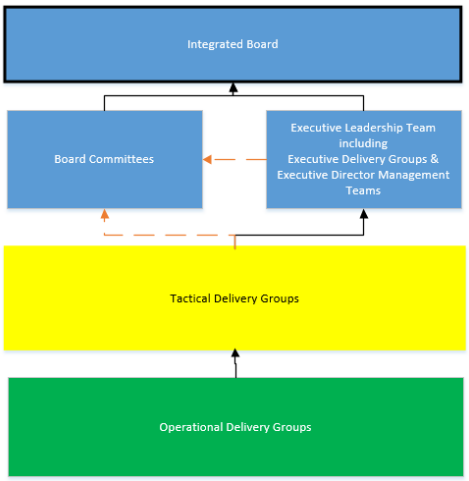


Figure 4 - Board and Executive Groups interface

3.2. Delivery Structure

The Executive Leadership Team heads the delivery arm of the Board in terms of both operational and strategic management. The Executive Leadership Team meets twice-weekly one meeting to focus on strategy the other to focus on operational delivery.

The model creates three cross-functional Executive Delivery Groups (EDG) for delivery of strategy. The Executive Delivery Groups are in effect an extension of the Executive Leadership Team, they derive their authority from the Executive Leadership team and are therefore accountable to the Executive Leadership team. However, they will work closely with Board committees and will provide reports and assurance directly to the Board Committees, for instance the Chair's Assurance Report will be a standing item on Board committee agendas (see section on Cycles of Business). The three EDGs are:

- Executive Delivery Group People and Culture.
- Executive Delivery Group Quality Improvement.
- Executive Deliver Group Transformation and Finance.

Each Delivery group will take on responsibility for co-ordinating and providing Board with evidence based strategic thinking in strategy development and providing evidence based assurance on delivery and impact.

The Delivery Group's responsibilities are configured differently to those of the Board Committees; this is to allow a different focus of challenge from at development and sign off stage.

These groups will drive the transformation agenda. They will ensure that the tactical and operational groups beneath them are functioning effectively (this is to become a standard role for each group wherever it sits in the structure which will enhance the effectiveness of meetings, line of sight from floor to board and support the functioning of the performance and accountability framework). Each Executive Delivery Group Chair will provide a Chairs Assurance Report for the relevant Board committee, which may be shared with other committees for information to support common understanding of strategy delivery across the Board Committees.

To support the Executive Leadership Team and strategic Board Committees there will be a tactical Planning and Strategy Group to coordinate planning, strategy development and alignment of strategic delivery. Time limited groups are in place to deliver on Board operational priorities.

Operational management will be conducted through the Executive Management Groups, which in essence are the current Senior Management Team meetings in each directorate. The purpose of these groups is to provide evidence-based plans for improvement and evidence based assurance on operational delivery and outcomes, the Executive Management Groups will also provide evidence and assurance directly to Board Committees.

This structure will enable the Executive Leadership Team (ELT) to manage and balance its working arrangements in relation to strategic leadership and operational leadership.

The Executive Leadership Team will be responsible for ensuring that there are no "orphaned" groups so a proper governance and reporting structure beneath them for

Tactical and Operational delivery. To avoid a renewed meeting culture any new group within the corporate structure will need ELT sign off.

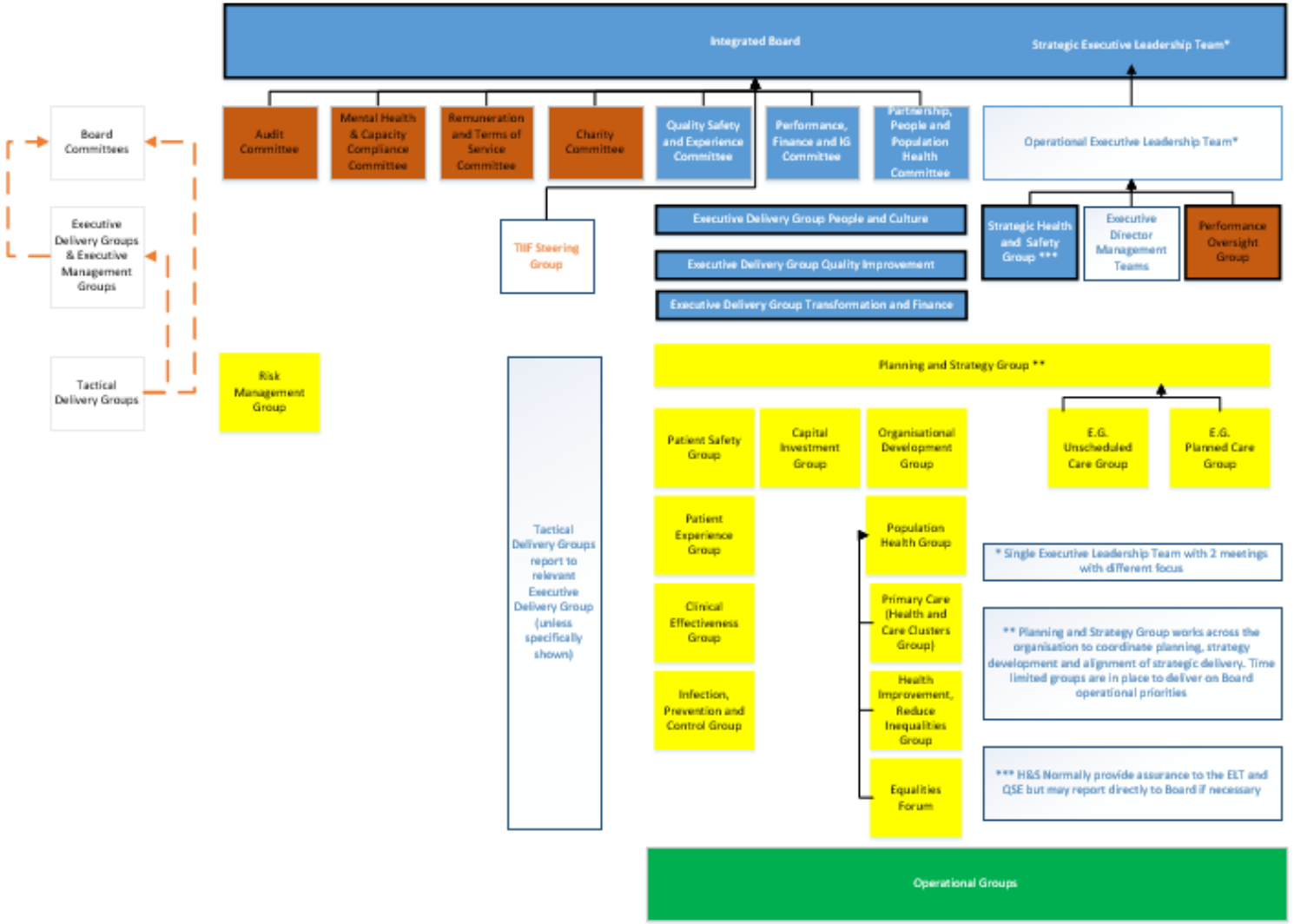

Integrated Board
Strategic Executive Leadership Team*
Board Committees
Audit Committee
Mental Health & Capacity Compliance Committee
Remuneration and Terms of Service Committee
Charity Committee
Quality Safety and Experience Committee
Performance, Finance and IG Committee
Partnership, People and Population Health Committee
Operational Executive Leadership Team*
Executive Delivery Groups & Executive Management Groups
TIIF Steering Group
Executive Delivery Group People and Culture
Executive Delivery Group Quality Improvement
Executive Delivery Group Transformation and Finance
Strategic Health and Safety Group ***
Executive Director Management Teams
Performance Oversight Group
Tactical Delivery Groups
Risk Management Group
Planning and Strategy Group **
Patient Safety Group
Capital Investment Group
Organisational Development Group
E.G. Unscheduled Care Group
E.G. Planned Care Group
Patient Experience Group
Population Health Group
Clinical Effectiveness Group
Primary Care (Health and Care Clusters Group)
Infection, Prevention and Control Group
Health Improvement, Reduce Inequalities Group
Equalities Forum
Tactical Delivery Groups report to relevant Executive Delivery Group (unless specifically shown)
* Single Executive Leadership Team with 2 meetings with different focus
** Planning and Strategy Group works across the organisation to coordinate planning, strategy development and alignment of strategic delivery. Time limited groups are in place to deliver on Board operational priorities
*** H&S Normally provide assurance to the ELT and QSE but may report directly to Board if necessary
Operational Groups

Figure 5 - Integrated Board Schematic

3.2.1. Strategic Tactical and Operational model

The Strategic Tactical and Operational model makes clear the purpose of groups, it limits the number of groups that can be seen as purely for assurance, moves away from groups having a purpose to 'assure' to groups having a purpose to 'deliver'. The evidence of delivery becomes the assurance. This model will be reflected in the Divisions, this structure, together with the Performance and Accountability Framework and the Chair's Assurance Reports starts to give more assurance of action and sight of front line teams to the Board.

3.3. Governance Handbook – ways of working

3.3.1. Cycles of Business

Cycles of business should be used to proactively manage the workload of committees and groups, streamlined to focus committee time to the most appropriate agenda's and comply with committee terms of reference.

Committees will be supported by an executive delivery structure to provide evidence and assurance and do some of the detailed work for the committees. The Cycles of Business are structure to support Board and committees balance their roles in strategy (the future), assurance (the present and learning from the past) while embedding culture. They are designed to cover all the Board and committee business over a year, but to give flexibility through Particular Areas of Concern Reports and the focus of the deep dives.

Innovations introduced in the attached committee cycles of business include:

- Having a patient story at Quality Committee.
- Standard report from the Chair to include feedback from Board.
- Standard report from the Lead Executive to inform members of matters that are important or innovative but would not require a full paper.
- Standard agenda item to receive feedback or notifications from other Board Committees.
- Inclusion of Directorate Operational Reports on a rolling basis to support the committee to get a broader view of activity within the organisation including challenges, celebrations, concerns and commendations and support the floor to board line of sight.
- Rolling Deep Dive Reports to allow meetings to focus on areas of responsibility and not take a shallow view at every meeting.
- Standard agenda item to refer matters to other Board Committees, if appropriate.
- Standard agenda item to review risks highlighted within the meeting and refer to the Risk Management Group if appropriate.
- Standard agenda item to agree items for the Chairs Assurance Report.
- Standard agenda item to review the effectiveness of the meeting.

3.3.1.1. Themes to support the Golden Thread from floor to Board

- Patient Story at Board and QSE Committee. This could be implemented immediately.
- Directorate Reports at Board and committee on a rotational basis covering challenges, celebrations, concerns and commendations. This could be implemented immediately.
- Deep dive into areas programmed across the business year to give a depth of focus in a meeting rather than a shallow overview at every meeting. This could be implemented immediately.
- Report of Lead Executive at committees to make members aware of issues not suitable for a full paper, this could be an oral or written report. This could be implemented immediately.
- Formal process to refer matters to other committees and receive matters from Board. This could be implemented immediately.
- Identification of risks arising within a meeting for referral to the Risk Management Group. This could be implemented immediately.
- Chairs Assurance Reports from relevant groups into committees for assurance and information. This could be implemented immediately.
- Formal reporting (via the lead Executive) from formal partnership arrangements and advisory groups to appropriate committees. This could be implemented immediately.
- Reviews of meeting effectiveness to capture learning and improvement.

3.3.2. Strategy Development and Monitoring

The Corporate Strategy (Living Healthier, Staying Well) is the top-level strategy that sets the direction for the organisation over the next period, a number of other strategies in specific areas will support the Corporate Strategy. Board oversight of the development and delivery of the Corporate Strategy will be via the Partnership, People and Population Health Committee, although other committees will have ownership of their section of the Corporate Strategy notably the Quality Safety and Experience Committee and the Performance, Finance and Information Governance Committee.

As the top-level strategy, the Corporate Strategy should identify the need for strategies for Board ownership (tier 1) and sub-strategies for Board information and committee ownership (tier 2). All strategies should be aligned to a Board Committee for ownership (where a strategy crosses the work of more than one committee the Board shall decide which committee takes primacy over the strategy).

Tier 1 (Board level strategies)

- Committees to develop strategy in accordance with the Corporate Strategy endorse and recommend to Board.
- Once Strategies approved committee will monitor implementation 6-monthly and report to board.

Tier 2 (Committee level strategies)

- Committees to develop strategy in accordance with the Corporate Strategy and any superior strategy and approve and notify Board (through the Chairs Assurance Report).
- Committee will monitor implementation 6-monthly and report to Board (through the Chairs Assurance Report) unless an area of specific concern or recommendation requires a full Board paper

When a strategy is presented to Board or committee, it should have a clear assurance paper attached to demonstrate.

- Audit of engagement.
- Outcome from engagement and consultation with
    - Staff.
    - Patients.
    - Partners.
    - The Public.
- Golden thread from the corporate strategy.
- Equality Impact Assessment.
- Public Sector Equality Duty (including socio-economic duty)

Where a strategy may impact the work of another committee either the Lead Executive or the common Independent Member committee member may refer all or part of a strategy to another committee for review.

3.3.3. Policy development and monitoring

Policies will be defined as

- Polices reserved for Board Approval (to be endorsed by relevant committee).
- Policies reserved for committee approval (to be endorsed by relevant Executive).
- Policies reserved for Executive Approval.

Through the Chairs Assurance Report / Lead Executives report a list of approved policies from the tier below will inform the committee or Board of policies that have been approved for information and challenge (re level of sign off) as appropriate.

3.3.4. Other ways of working

- Coordinated Agendas and Cycles of Business, the future, the present and learning from the past.
- Consistency in use of the Cover Sheets.
- Agenda setting: Independent Member Chair and lead Executive Director should draft the agenda based on the Cycle of Business and noting Particular Area of Concern reports, deep dives, directorate presentations and Chair s Assurance reports from junior Groups. Once the draft agenda is approved by the committee chair it cannot be changed without the express permission of the committee chair.
- Agenda to link risks identified in meetings back to the Risk management Group and have formal information flow between committees.

- Consistent use of Chair's Assurance Reports to parent group for assurance and accountability.
- Consistent Terms of Reference: parent groups responsible for:
    - The governance structures beneath them.
    - Regularly testing the information cascade / escalation.
    - Identifying 'orphaned' groups within their remit.

3.4. Governance in practice – Scenarios

3.4.1. Risk – Primary and triangulation routes

A member of staff in primary care identifies a significant risk. The member of staff discusses the risk with their line manager and raises it on Datix.

- Primary Route – Datix - the risk should then be discussed at team meetings and depending on the risk score will rise to divisional risk meetings through to the Risk Management Group, Executive Leadership Team and relevant Board Committee.
- Route 2 – Performance and Accountability Framework – all performance meetings (throughout the organisation) should discuss risks – not just those currently on the risk register but also emerging risks, this route should rise through to the Performance Oversight Group and thereon to Executive Leadership Team and relevant Board Committee. A regular meeting is in place between the Performance Team and Risk Team to cross-reference risks that have been reported on Datix and those raised in performance meetings.
- Route 3 – Standard Meeting Practice - risk should be a standard agenda item on all meeting agendas (including the identification of new risks within the meeting (see proposed Board Cycles of Business (annexes 18-20)). Appropriate risks should be included in the Chairs Assurance Report for information or escalation and through either line management or strategy delivery route to the appropriate Executive Director, Executive Leadership Team and Board Committee. If it is later discovered a risk was raised but not escalated this route also provides the evidence trail to better understand and learn why the risk was not escalated.

In principle, this also triple route also applies to incidents.

3.4.2. Floor to Board – Primary and triangulation routes

A member of staff in a hospital identifies an area of innovation or best practice. The member of staff discusses this with their line manager.

- Route 1 – Performance and Accountability Framework – all performance meetings throughout the organisation should discuss items to celebrate and things to be proud of, this route should rise through to the Performance Oversight Group and thereon to Executive Leadership Team and relevant Board Committee.
- Route 2 – Standard Meeting Practice – items to celebrate should be encouraged for discussion on all meeting agendas. Appropriate items should

be included in the Chairs Assurance Report for information and through either line management or strategy delivery route to the appropriate Executive Director, Executive Leadership Team and Board Committee. If it is later discovered best practice was raised but not escalated this route also provides the evidence trail to better understand and learn why it was not shared.

- Route 3 - Board Committee Directorate Operational Reports – these will be designed to support Independent Members gain a more holistic oversight of the challenges, celebrations, concerns and commendations throughout the organisation.

3.5. How does this meet the objectives?

3.5.1. Objective 1: Ensure that the work of the Board and committees are pitched at the right level and balance their responsibilities in strategy, culture and accountability.

By undertaking some of the analytical, research, and evaluation work the committees Executive Delivery Groups and associated Tactical Groups will create space for the Board Committees to balance their agendas. Proactive use of the Cycles of Business, associated agendas and meeting evaluation will highlight the balance of time a committee spends in each area. The quality of the evidential reports provided by Executive Delivery Groups and Executive Management Groups will be key to ensuring the pitch of oversight vs detailed investigation is met. Where aligned, the Executive Delivery Group will take lead responsibility for co-ordinating reporting from Executive Management Groups and Executive Delivery Groups to ensure consistent reporting between the present and the progress along the transformation route.

3.5.2. Objective 2: Develop a greater focus on strategy in committee – delivering for the future.

Incorporating relevant strategies into each committee terms of reference, combined with defining committee responsibilities within the corporate strategy will clarify ownership of strategy; this together with an aligned delivery structure reporting into the committees should provide the framework to appropriate focus on strategy.

3.5.3. Objective 3: Improve the focus, co-ordination and relevance of Board and committee papers with built in assurance levels.

The effect of consistent use of the Chairs Assurance Reports, together with the strategic, tactical, operational delivery structure and no orphaned groups rule will improve accountability (linked to the Performance and Accountability Framework) and ultimately assurance in that where challenges, celebrations, concerns and commendations are not escalated will be easier to trace back, understand why and learn.

The effective use of cycles of business and committee agendas will also allow for a balance of committee business within the meeting, and across the year to support Independent members to get a deeper understanding of the challenges, celebrations, concerns and commendations within the operational teams.

3.5.4. Objective 4: Give the Board clear line of sight over business as usual and strategic delivery structures, including lines of accountability to provide better assurance and reduce duplication.

The structure aims to give a clear line of accountability for performance through the Executive Management Groups, supported by the Performance and Accountability Framework and the Performance Oversight Group. Enabling the Chief Executive to hold Executive Directors to account for performance and the Board to hold the Executive Leadership Team to account for performance management. (Also this partly meets objective 4).

3.5.5. Objective 5: Develop greater oversight of the People / Transformation agenda.

Covered within the Terms of Reference for the Partnerships, People and Population Health Committee.

3.5.6. Objective 6: Improve information flow: no orphan groups - improve the line of sight from Floor to Board through increased governance discipline.

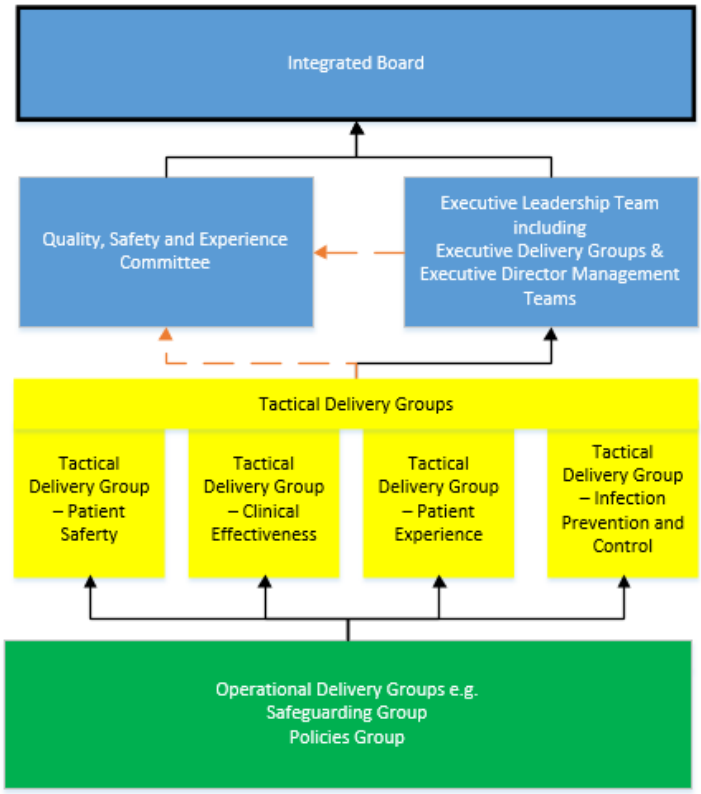
This will be resolved through having clear reporting lines for groups and committees, linked to consistent use of the chairs assurance reports, which will highlight areas of challenges, celebrations, concerns and commendations. Committees and Board will also have the opportunity to hear first-hand from the front line during the programmed directorate reviews within the cycles of business.

4. Indicative Timeline

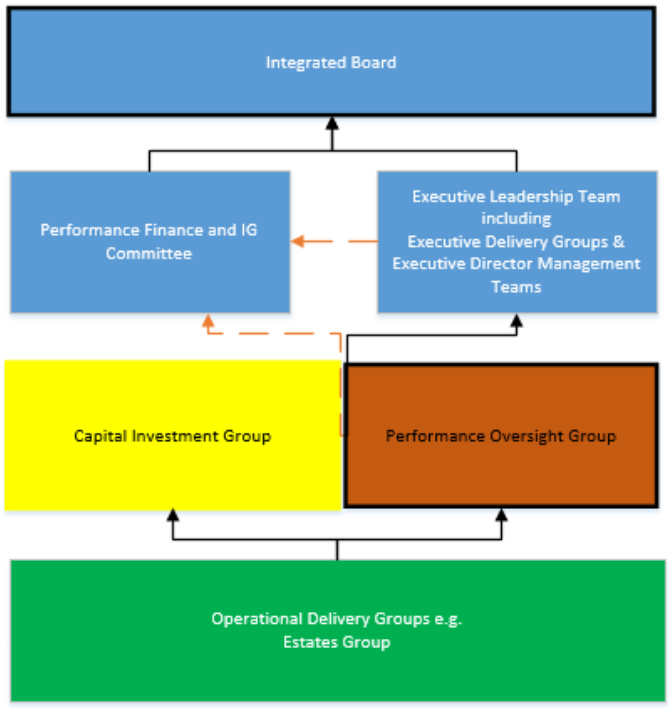
- 20 May 2021 Board Approval in principle
- Full Workup
- 10 June 2021 Audit Committee – Detailed workup approval (SO / ToR etc.)
- 01 August Implementation

Annexes 1 – 3 Committee support structures

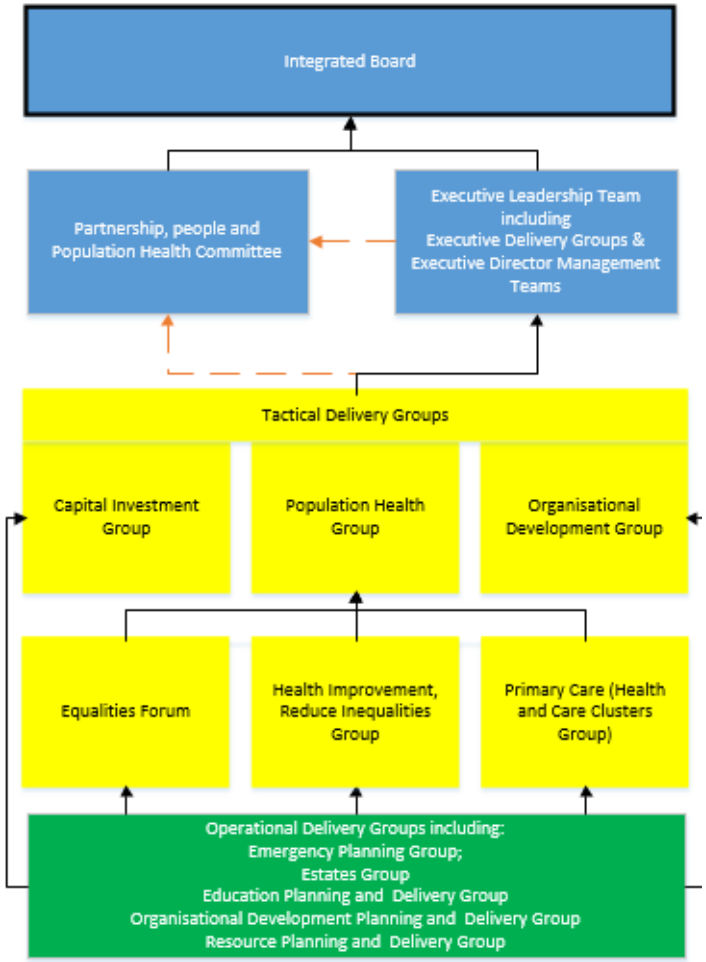
Annex 1 – Quality, Safety and Experience Committee Supporting Structure.



Annex 2 – Performance, Finance and Information Governance Committee Supporting Structure.



Annex 3 – Partnerships, People and Population Health Committee Supporting Structure.



Annexes 4 – 17 Outline Terms of Reference.

Annex 4 - *Commonality – Board Committees.*

Designation	WG requirement – Strategic Board Assurance Committee or BCUHB requirement – Strategic Board Assurance Committee
Purpose	Within the remit of the committee: 1. Provide evidenced based assurance that there is compliance with: 1. The Equalities Act 2010. 2. In discharging its duty the Committee will have 'due regard' to the Public Sector Equality Duty, to eliminate discrimination, to advance equality of opportunities and foster good relations when carrying out all functions and day-to-day activities. 3. In discharging its duty the Committee will have 'due regard' to the Socio-economic Duty, to consider how strategic decisions might help reduce the inequalities associated with socio-economic disadvantage. 4. ~~1.~~5. The Human Rights Act 1998. ~~2.~~6. The United Nations Convention on the Rights of People with Disabilities. ~~3.~~7. BCUHB Policy. 2. Provide evidence based and timely advice to the Board on developing ~~appropriate~~ strategies. 3. Provide evidence based and timely advice to the Board on the delivery of strategies. 4. Oversee and provide evidence based and timely advice to the Board on relevant risks and concerns. 5. Receive the results of relevant audits (clinical and non-clinical) and any other relevant investigations and provide the Board with evidence based impact assessment of the implementation of the recommendations. 1. Seek assurance that outcomes for patients are delivered through partnership arrangements where that is beneficial for the patient 6. ~~Partnership focus on delivery~~
Attendance	Board Secretary, by invitation any Executive Director, Chair of the Audit Committee to have a right of attendance

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Reports to	Board – Annual report on the work of the committee, plus Chair's Summary Assurance report to the Board following each meeting of the committee
Gains assurance from	Executive Leadership Team, Executive Delivery Groups, Executive Management Groups
Sub-Groups	None

Annex 5 - *Audit Committee.*

Designation	WG requirement – Strategic Board Assurance Committee
Purpose	1. Evidenced based and timely advice to the Board and the Accountable Officer on the assurance frameworks to support them in their decision taking and in discharging their accountabilities for securing the achievement of BCUHB's objectives 2. Evidence based assurance to the Board and the Accountable Officer on whether effective arrangements are in place through the operation of the UHB's assurance framework 3. Evidence based assurance to the Board and the Accountable Officer on the effectiveness of Risk Management, Performance Management and other areas as defined by the Board or Accountable officer from time to time
Scope	All activities undertaken, provided or commissioned (clinical and non-clinical) by the Health Board
Membership	4 x Independent Members (one of whom shall be the committee chair)
Attendees	Chief Executive, Director of Finance, (Lead), Executive Director of Nursing and Midwifery/Deputy Chief Executive, Director of Governance, Head of Internal Audit, Local Counter Fraud Specialist, External Auditor.
By invitation	Any Executive Director
Frequency	Quarterly
Reporting Group(s)	(i) Risk Management Group

Annex 6 - *Mental Health & Capacity Compliance Committee.*

Designation	WG requirement – Strategic Board Assurance Committee
Purpose	1. 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) 2. Provide evidence based assurance to the Board that Hospital Managers' duties under the MHA, the functions and processes of discharge under section 23 under the MHA, the provisions laid out in the MCA and the Measure are all exercised in accordance with statute and that there is compliance with the MHA and Code of Practice for Wales and the MCA Code of Practice and the DoLS Code of Practice and the associated regulations
Scope	All services provided to patients with mental health mental health, wherever the setting.
Membership	~~4~~ 3 x Independent Members (one of whom shall be the vice-chair of the Board who shall chair this committee)
Attendees	Executive Director of Public Health (Lead), Executive Director of Nursing and Midwifery/Deputy Chief Executive, Executive Director of Primary Care and Community Services, Medical Director for Mental Health, Nurse Director for Mental Health, Director of Mental Health, representatives from Hospital Managers, Service Users, Carers, North Wales Police, Welsh Ambulance Service, IMCA, IMHA, DoLS Manager, MCA Manager.
By invitation	Any Executive Director
Frequency	Bi-monthly
Reporting Group(s)	None

Annex 7 ~~*Charity*~~*Charitable Funds Committee.*

Designation	WG requirement – Strategic Board Assurance Committee
Purpose	BCUHB is the Corporate Trustee of its charitable funds and the Board serves as its agent in the administration of the charitable funds held. 1. Evidenced based and timely advice to the Board and the Accountable Officer in the discharge of its duties for Charitable Funds 2. Discharge delegated responsibility from the corporate Trustee for the control and management of Charitable Funds 3. Evidence based assurance to the Board and the Accountable Officer on compliance with Trustee Act 200, The Charities Acts 1993, 1996, 2011 & 2016, and the Terms of the Funds' Governing arrangements
Scope	Administration of all existing charitable funds, fundraising, priorities and spending criteria
Membership	~~4~~ 3 x Independent Members (one of whom shall be the committee chair) and Executive Director of Finance (Lead), Executive Director of Planning and Performance, Executive Director of Nursing and Midwifery/Deputy Chief Executive
Attendees	Head of Financial Services, Charitable Funds Accountant, Charitable Funds Fundraising Manager, Investment Advisor
By invitation	Any Executive Director
Frequency	Quarterly
Reporting Group(s)	None

Annex 8 *Remuneration and Terms of Service Committee.*

Designation	WG requirement – Strategic Board Assurance Committee
Purpose	1. Evidenced based and timely 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; 2. Evidence based assurance to the Board and the Accountable Officer 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
Scope	All employment contracts entered into by BCUHB, additional payments (e.g. redundancy, retention), professional registrations
Membership	4 x Independent Members (one of whom shall be the committee chair) and one of whom shall be the Chair of the Audit Committee. A Trade Union Partner Chair of the Local Partnership Forum will attend at meetings held in public as an ex-officio member.
Attendees	Chief Executive, Executive Director of Workforce and Organisational Development (Lead), Executive Medical Director
By invitation	Any Executive Director
Frequency	Quarterly
Reporting Group(s)	None

Annex 9 *Quality, Safety and Experience Committee.*

Designation	WG requirement – Strategic Board Assurance Committee
Purpose	1. Evidence based and timely advice to the Board on quality, safety & experience of Health Services 2. Evidence based and timely advice to the Board on quality, safety & experience of public health, health promotion and health protection 3. Evidence based assurance on safeguarding and improving the quality the quality and safety of patient and citizen centred health 4. Evidenced based assurance to the Board on improving patient, care and citizen experience, including services deliver by partnership 5. Development and oversight of patient related strategies including quality, clinical effectiveness, patient safety and patient experience
Scope	All services provided or commissioned by the Health Board, including acute, community, primary care, and mental health services
Membership	~~4~~ 3 x Independent Members (one of whom shall be the committee chair)
Attendees	Executive Director of Nursing and Midwifery/Deputy Chief Executive, Executive Medical Director, Executive Director of Therapies and Health Sciences, Executive Director of Public Health, Executive Director of Primary Care and Community Services, Assistant Director of Patient Safety and Quality, Assistant Director of Patient Experience. Associate Director of Quality Assurance Director of Mental Health & Learning Disabilities. Senior Associate Medical Director. Chair of Healthcare Professionals Forum. Associate Board Member Representative of Community Health Council.
By invitation	A patient representative, a staff representative, Executive Director of Planning and Performance.
Frequency	Bi-monthly
Reporting Group(s)	(i) Executive Delivery Group for Quality Improvement ~~(i)~~(ii) Clinical Effectiveness Group; ~~(ii)~~(iii) Patient Experience Group;

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	~~(iii)~~(iv) Patient Safety Group; ~~(iv)~~(v) Health and Safety Group

Annex 10 *Performance, Finance and IG Committee.*

Designation	IG is WG requirement other functions BCUHB Discretion – Strategic Board Assurance Committee
Purpose	1. Evidence based and timely advice to the Board on the financial performance of the Health Board and developing the IMTP 2. Evidence based and timely advice to the Board on operational performance of the Hearth Board and associated Impact Improvement Plans 3. Evidence based assurance on the financial position, forecasting, and the capital programme 4. Evidence based assurance to the Board and accountable officer on whether effective arrangements are in place through the operation of the governance framework for data processing and information management 5. Development and oversight of finance and performance related strategies
Scope	All services provided or commissioned by the Health Board, including acute, community, primary care, and mental health services
Membership	~~4~~ 3 x Independent Members (one of whom shall be the committee chair)
Attendees	Director of Finance, (Lead), Executive Director of Nursing and Midwifery/Deputy Chief Executive, Executive Director of Planning and Performance, Executive Medical Director
By invitation	A patient representative, a staff representative,
Frequency	Bi-monthly
Reporting Group(s)	(i) Capital Investment Group

Annex 11 Partnerships, People and Population Health Committee.

Designation	BCUHB Discretion – Strategic Board Assurance Committee
Purpose	1. Evidence based and timely advice to the Board on our staff and potential staff matters 2. Evidence based and timely advice to the Board on population health outcomes and prevention strategies 3. Evidence based assurance on transformation capacity, delivery and planning 4. Evidenced based assurance to the Board on corporate strategy delivery improving outcomes for citizens, including services deliver by partnership 5. Development and oversight key enabling strategies of people, transformation and digital related strategies
Scope	All services provided or commissioned by the Health Board, including acute, community, primary care, and mental health services
Membership	~~4~~ 3 x Independent Members (one of whom shall be the committee chair)
Attendees	Executive Director of Planning and Performance (Lead), Executive Director of Workforce and OD, Executive Medical Director, Executive Director of Nursing and Midwifery/Deputy Chief Executive, Executive Director of Therapies and Health Sciences, Executive Director of Public Health, Executive Director Primary and Community Services .
By invitation	A patient representative, a staff representative, any other Executive Director
Frequency	Bi-monthly
Reporting Group(s)	(i) Population Health Group (including Equalities Forum / Health Improvement Reduce Health Inequalities Group / Primary Care (Health and Care Clusters Group): (ii) Organisational Development Group

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Annex 12 *Executive Leadership Team Meeting.*

Designation	BCUHB requirement – Strategic Delivery Group
Purpose	The executive decision making group of the organisation: 1. Ensuring the effective operational co-ordination of all organisational functions, and supporting the Chief Executive to discharge the responsibilities delegated to the Accountable Officer. 2. Provide evidenced based assurance to the Board that there is compliance with 1. The Equalities Act 2010 ~~1.~~2. The Human Rights Act 1998 ~~2.~~3. The United Nations Convention on the Rights of People with Disabilities ~~3.~~4. BCUHB Policy 3. To provide evidence based advice and assurance concerning all aspects of setting and delivering the strategic direction for the Board, the delivery of its associated strategies, plans the delivery of national requirements and the quality of services, performance and financial management, and associated operational planning and delivery of the Health Board; 4. To support and advise the Board and its Committees in exercising its key functions; 5. To ensure effective operational management of the Health Board, enabling critical issues to be anticipated, discussed, action plans agreed and that there is appropriate integration, connection and liaison between individual services, clinical and corporate functions and between strategic and operational matters; 6. To ensure the organisation remains fit for purpose by continuously reviewing effectiveness and efficiency of the organisational structure and support functions; 7. Oversee and provide evidence based and timely advice to the Executive Leadership Team on relevant Risks including BAF Risks
Attendance	All Executive Directors, the Board Secretary
Reports to	Board
Gains assurance from	Executive Leadership Team members and sub groups
Sub-Groups	(i) Executive Delivery Group - People and Culture,

	(ii) Executive Delivery Group - Transformation & Finance (iii) Executive Delivery Group - Quality Improvement, (iv) Performance Oversight Group, (v) Strategic Health and Safety Group ~~(v)~~(vi) Risk Management Group

Annex 13 *Commonality – Executive Delivery Groups.*

Designation	BCUHB requirement – Strategic Delivery Group

Purpose	Within the remit of the committee:
	1. **Oversight of delivering the board strategy form current state to future state**
	2. Provide evidenced based assurance to the Executive Leadership Team that there is compliance with
	  1. The Human Rights Act 1998
	  2. The United Nations Convention on the Rights of People with Disabilities
	  3. BCUHB Policy
	3. Provide evidence based and timely advice to the Executive Leadership Team on developing, implementation, monitoring, and impact of relevant sections of the Corporate Strategy
	4. Provide evidence based and timely advice to the Executive Leadership Team on developing, implementation, monitoring, and impact of relevant sub-strategies
	5. Oversee and provide evidence based and timely advice to the Executive Leadership Team on relevant Risks including BAF Risks
	6. Receive the results of relevant audits (clinical and non-clinical) and any other relevant provide the Executive Leadership Team with evidence based impact assessment of the implementation of the recommendations
	7. Approve or endorse relevant policies

Attendance	TBA
Reports to	Executive Leadership Team (ELT) –Chair's Summary Assurance report to ELT following each meeting of the Group
Accountable to	Executive Leadership Team,
Provides evidence	Provide assurance reports to the Board Committees

Annex 14 *Executive Delivery Group People and Culture*.

Designation	BCUHB requirement – Strategic Delivery Group
Purpose	1. Strategy development, implementation, monitoring and evaluation within TOR 2. Development and oversight of Health and Safety, Equality, Education, Organisational Development and resource planning 3. Addressing relevant concerns from the Performance Oversight group in relation to the operational function and performance metrics of the Workforce and OD Directorate 4. Provide evidence based assurance and advice to the Executive Leadership Team to ensure effective governance arrangements are in place to enable the cascade and escalation of issues pertinent to the purpose of this group.
Scope	All services provided or commissioned by the Health Board, including acute, community, primary care, and mental health services
Membership	Executive Director of Workforce and Organisational Development (Chair), 1 other Executive Director, Chair of Each Tactical Sub Group, Senior representatives from Nursing, Medical, Therapies, PH, Finance, Planning
Attendees	TBA
By invitation	A patient representative, a staff representative, any other Executive Director
Frequency	Monthly or 6 weekly
Sub-Groups	(i) Health & Safety (ii) Equalities (iii) Education (iv) Organisational Development (v) resources (vi) Secondary Care (vii) Mental Health (viii) Community & Primary Care

Annex 15 *Executive Delivery Group Transformation & Planning.*

Designation	BCUHB requirement – Strategic Delivery Group
Purpose	1. Strategy development, implementation, monitoring and evaluation within TOR 2. Development and oversight of Transformation Programmes, Planning and Capital 3. Addressing relevant concerns from the Performance Oversight group in relation to the operational function and performance metrics of the Strategy and Planning Directorate 4. Provide evidence based assurance and advice to the Executive Leadership Team to ensure effective governance arrangements are in place to enable the cascade and escalation of issues pertinent to the purpose of this group. 5. Prime responsibility to develop the corporate strategy and IMTP plans 6. Evaluation of the impact of the strategy on public health and prevention 7. Innovation and the Digital Agenda
Scope	All services provided or commissioned by the Health Board, including acute, community, primary care, and mental health services
Membership	Executive Director of Strategy and Planning (Chair), 1 other Executive Director, Chair of Each Tactical Sub Group, Senior representatives from Nursing, Medical, Therapies, PH, Finance, WOD
Attendees	TBA
By invitation	A patient representative, a staff representative, any other Executive Director
Frequency	Monthly or 6 weekly
Sub-Groups	(i) Capital Investment (ii) Transformation Oversight (a) Planned Care) (b) Unscheduled Care (c) Mental Health (iii) Planning Oversight (a) Civil Contingencies (iv) Digital Driver

Annex 16 *Executive Delivery Group Quality Improvement.*

Designation	BCUHB requirement – Strategic Delivery Group
Purpose	1. Strategy development, implementation, monitoring and evaluation within TOR 2. Development and oversight of Clinical Effectiveness, Patient Experience and Patient Safety 3. Addressing relevant concerns from the Performance Oversight group in relation to the operational function & performance metrics of the Nursing, Medical and Therapies Directorates 4. Provide evidence based assurance and advice to the Executive Leadership Team in relation to safeguarding 5. Provide evidence based assurance and advice to the Executive Leadership Team to ensure effective governance arrangements are in place to enable the cascade and escalation of issues pertinent to the purpose of this group.
Scope	All services provided or commissioned by the Health Board, including acute, community, primary care, and mental health services
Membership	Executive Director of Nursing (Chair), Executive Medical Director, Executive Director of Therapies and Health Sciences, Chair of Each Tactical Sub Group, Senior representatives from, PH, Finance, WOD
Attendees	TBA
By invitation	A patient representative, a staff representative, any other Executive Director
Frequency	Monthly or 6 weekly
Sub-Groups	(i) Patient Experience (ii) Clinical Effectiveness (iii) Patient Experience

Annex 17 *Executive Delivery Group Financial Sustainability.*

Designation	BCUHB requirement – Strategic Delivery Group
Purpose	1. Strategy development, implementation, monitoring and evaluation within TOR 2. Development and oversight of financial sustainability and programmes 3. Addressing relevant concerns from the Performance Oversight group in relation to the operational function & performance metrics of Finance Directorate 4. Provide evidence based assurance and advice to the Executive Leadership Team in relation to financial probity 5. Provide evidence based assurance and advice to the Executive Leadership Team to ensure effective governance arrangements are in place to enable the cascade and escalation of issues pertinent to the purpose of this group.
Scope	All services provided or commissioned by the Health Board, including acute, community, primary care, and mental health services
Membership	Executive Finance (Chair), 1 other Executive Director, Chair of Each Tactical Sub Group, Senior representatives from Nursing, Medical, Therapies, PH, Planning, WOD
Attendees	TBA
By invitation	A patient representative, a staff representative, any other Executive Director
Frequency	Monthly or 6 weekly
Sub-Groups	(i) Programme Management

Annexes 18-20 Draft Cycles of Business

Annex 18 - DRAFT Performance, Finance and Information Governance CYCLE OF BUSINESS / Information flow.

Also meets in January and March specifically to consider the annual plan.

Agenda item	Apr	Jun	Aug	Oct	Dec	Feb
Governance						
Apologies	✓	✓	✓	✓	✓	✓
Declaration of Interests	✓	✓	✓	✓	✓	✓
Minutes from previous meeting	✓	✓	✓	✓	✓	✓
Matters Arising & Table of Actions	✓	✓	✓	✓	✓	✓
Report of the Chair • Chair's Action • **Feedback from Board**	✓ ✓ ✓	✓ ✓ ✓	✓ ✓ ✓	✓ ✓ ✓	✓ ✓ ✓	✓ ✓ ✓
Report of the Lead Executive	✓	✓	✓	✓	✓	✓
Notification of Matters referred from other Board Committees on this or future agendas	#	#	#	#	#	#
Strategic Items for Decision – The Future						
Developing New Strategies or Plans						
Annual Financial Plan	ToR					✓
Corporate Strategy - Financial						
Tier 1 Strategies for Board Approval – to be defined in the corporate strategy (Living Healthier, Staying Well) • Financial aspects of corporate strategy • Financial Aspects of IMTP • Financial / Sustainability Strategy • Information Governance Strategy						✓
Tier 2 Strategies for committee approval – to be defined in the corporate strategy (Living Healthier, Staying Well) • Estates • Environmental • Performance Management Framework • Decarbonisation Strategy				 ✓	✓ ✓ ✓	
Monitoring Existing Strategies or plans						
Corporate Strategy (Financial Monitoring Report)						
Monitoring Tier 1 Strategies on behalf of the Board – as defined in the corporate strategy • Financial aspects of corporate strategy					✓	

Agenda item	Apr	Jun	Aug	Oct	Dec	Feb
• Financial Aspects of IMTP • Financial / Sustainability Strategy • Information Governance Strategy						
Monitoring Tier 2 Strategies for committee approval – as defined in the corporate strategy) • Estates • Environmental • Performance Management Framework • De-carbonisation Strategy	✓			✓	✓ ✓ ✓	
Other						
Endorse relevant policies reserved for Board approval	#	#	#	#	#	#
Agree relevant polices reserved for committee approval	#	#	#	#	#	#
Financial Instructions						✓
Annual Capital Programme	✓					
Transforming Services - Outcomes • Mental Health • Planned Care • Primary and Community Care • Unscheduled Care	✓ ✓	✓ ✓	✓ ✓	✓ ✓	✓ ✓	✓ ✓
Recommendations from the Primary Care Panel to take on new GP practices	#	#	#	#	#	#
Quality Safety and Performance – The Present (for Assurance)						
Board Assurance Framework		✓			✓	
Corporate Risk Register		✓			✓	
Finance Report (including workforce cost report)						
Divisional Operational Finance Reports • Finance • Mental Health • Primary and Community Care (including Therapies) • • Public Health • Secondary Care (including North Wales Managed Services) • • Strategy and Planning • ~~Therapies~~ • Women's and Children's • Workforce and OD	✓ ✓ ✓	✓ ✓ ✓	✓ ✓ ✓	✓ ✓ ✓	✓ ✓ ✓	✓ ✓ ✓

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Agenda item	Apr	Jun	Aug	Oct	Dec	Feb
Integrated Performance Report (incorporating seeing services from the front line) • Finance • Performance	✓	✓	✓	✓	✓	✓
Report from Performance Oversight Group	✓	✓	✓	✓	✓	✓
Financial Planning process						✓
Capital Programme Monitoring Report			✓			✓
External Contracts Assurance Report	✓			✓		
Shared Services Partnership Assurance Report		✓			✓	
Assurance reports on Particular Areas of Concern – time limited	#	#	#	#	#	#
Welsh Government Monthly Monitoring Return	✓	✓	✓	✓	✓	✓
Capital and Estates Business Cases	#	#	#	#	#	#
Benefits Realisation Gateway Reviews	#	#	#	#	#	#
Medical Locum Doctors including Junior Doctors rota, medical and dental agency locums report	#	#	#	#	#	#
Learning from – The Past						
Independent Assurance Reviews	#	#	#	#	#	#
Internal Assurance Reviews	#	#	#	#	#	#
Relevant Ombudsman reports	#	#	#	#	#	#
Chairs Assurance Reports / Lead Executive Triple A Report						
Chairs Assurance Reports (for assurance) • Executive Delivery Group – Transformation and Finance • Capital Investment Group • Performance Oversight Group	✓	✓	✓	✓	✓	✓
Chairs Assurance Reports (for information) • Executive Delivery Group – People and Culture • Executive Delivery Group - Quality Improvement	✓	✓	✓	✓	✓	✓
Other						
Annual Work plan						✓
						✓
						✓
Closing Business						

Agenda item	Apr	Jun	Aug	Oct	Dec	Feb
Agree Items for referral to Board / Other committees	✓	✓	✓	✓	✓	✓
Review of Risks highlighted in the meeting for referral to Risk Management Group	✓	✓	✓	✓	✓	✓
Agree items for Chairs Assurance Report	✓	✓	✓	✓	✓	✓
Review of Meeting Effectiveness	✓	✓	✓	✓	✓	✓

Annex 19 DRAFT PPPH CYCLE OF BUSINESS / Information flow.

Agenda item	Apr	June	Aug	Oct	Dec	Feb
Opening Business						
Apologies	✓	✓	✓	✓	✓	✓
Declaration of Interests	✓	✓	✓	✓	✓	✓
Minutes from previous meeting	✓	✓	✓	✓	✓	✓
Matters Arising & Table of Actions	✓	✓	✓	✓	✓	✓
Report of the Chair • Chair's Action • **Feedback from Board**	✓ ✓ ✓	✓ ✓ ✓	✓ ✓ ✓	✓ ✓ ✓	✓ ✓ ✓	✓ ✓ ✓
Report of the Lead Executive	✓	✓	✓	✓	✓	✓
Notification of Matters referred from other Board Committees on this or future agendas	#	#	#	#	#	#
Strategic Items for Decision – The Future						
Developing New Strategies or Plans						
Corporate Strategy	✓	✓				
Tier 1 Strategies for Board Approval – to be defined in the corporate strategy (Living Healthier, Staying Well) • IMTP • Transformation (TBC) • Digital • Partnership (TBC) • Organisational Development	✓	✓	✓ ✓ ✓	✓		
Tier 2 Strategies for committee approval – to be defined in the corporate strategy (Living Healthier, Staying Well) • Recruitment and Retention (TBC) • Equalities • Third sector engagement strategy (TBC)					✓	
Monitoring Existing Strategies or plans						
Monitoring Tier 1 Strategies on behalf of the Board – as defined in the corporate strategy) • IMTP • Transformation • Digital • Partnership • Organisational Development	✓ ✓	✓	✓ ✓ ✓	✓ ✓	✓	✓ ✓ ✓
Monitoring Tier 2 Strategies for committee approval – as defined in the corporate strategy) • Recruitment and Retention • Equalities	✓	✓		✓	✓	

Agenda item	Apr	June	Aug	Oct	Dec	Feb
Other						
Endorse relevant policies reserved for Board approval	#	#	#	#	#	#
Agree relevant polices reserved for committee approval	#	#	#	#	#	#
Policy status update including relevant policies reserved for Executive approval			✓			✓
Staff Survey						
Winter Plan			✓	✓		
Major Incident Plan / Civil Contingencies Act		✓			✓	
Regional Partnership Board	✓			✓		
Partners Strategy Presentations	#	#	#	#	#	#
Quality Safety and Performance – The Present						
Board Assurance Framework related to committee	✓			✓		
Corporate Risk Register	✓			✓		
Directorate Operational Reports (incorporating seeing services from the front line) • **Public Health (Including Adverse Child Experience, Smoking Cessation, Healthy Lives, Well North Wales Inequalities, Alcohol Use, Vulnerable Groups)** • **Workforce and OD** • **Strategy and Planning** • **Population Health (including Primary Care Clusters, Health Inequalities, and Public Sector Equality Duty)**	✓	✓ ✓	✓	✓	✓ ✓	✓
Assurance reports on Particular Areas of Concern – time limited	#	#	#	#	#	#
Staff Survey and quarterly Pulse Reports		✓	✓		✓	✓
Workforce Report		✓			✓	
Population Health Report			✓			✓
Freedom to Speak Up Guardian Report	✓			✓		
Corporate Health at Work	✓			✓		
IMTP - Annual Plan and compliance with the Wellbeing of Future Generations (Wales) Act (2015)		✓			✓	✓
Welsh Language			✓			✓
Partnership Governance Arrangements	✓			✓		
Test and Trace Programme Update (short life)	✓	✓	✓	✓	✓	✓

Agenda item	Apr	June	Aug	Oct	Dec	Feb
Consultations and Engagement Outcomes Report		✓			✓	
Annual Reports						
Committee Annual Report to Audit Committee	✓					
Review Committee Terms of Reference	✓					
Community Health Council Annual Report		✓				
Equality Annual Report		✓				
Workforce Annual Report		✓				
Learning from – The Past						
Independent Assurance Reviews	#	#	#	#	#	#
Internal Assurance Reviews	#	#	#	#	#	#
Public Ombudsman reports	#	#	#	#	#	#
Chairs Assurance Reports / Lead Executive Triple A Report						
Chairs Assurance Reports from Strategic and Tactical Delivery Groups (for assurance) • Executive Delivery Group – People and Culture • Executive Delivery Group – Transformation and Finance • Population Health Group • Capital Investment Group	✓ ✓ ✓ ✓	✓ ✓ ✓ ✓	✓ ✓ ✓ ✓	✓ ✓ ✓ ✓	✓ ✓ ✓ ✓	✓ ✓ ✓ ✓
Chairs Assurance Reports (for information) • Executive Delivery Group - Quality Improvement	✓	✓	✓	✓	✓	✓
Partnership Meetings • Regional Partnership Board • Public Service Board – Gwynedd and Anglesey • Public Service Board – Flintshire • Public Service Board – Wrexham and Denbighshire • Public Service Board – Conwy • Together for Mental Health Partnership Board • Mid Wales Collaborative Agreement	✓ ✓ ✓	✓ ✓	✓ ✓ ✓	✓ ✓ ✓	✓ ✓	✓ ✓ ✓
Other						
Closing Business						

Agenda item	Apr	June	Aug	Oct	Dec	Feb
Agree Items for referral to Board / Other committees	✓	✓	✓	✓	✓	✓
Review of Risks highlighted in the meeting for referral to Risk Management Group	✓	✓	✓	✓	✓	✓
Agree items for Chairs Assurance Report	✓	✓	✓	✓	✓	✓
Review of Meeting Effectiveness	✓	✓	✓	✓	✓	✓

Annex 20 DRAFT Quality, Safety and Experience Committee CYCLE OF BUSINESS / Information flow.

Agenda item	Mar	May	Jul	Sep	Nov	Jan
Opening Business						
Patient/Staff Story	✓	✓	✓	✓	✓	✓
Apologies	✓	✓	✓	✓	✓	✓
Declaration of Interests	✓	✓	✓	✓	✓	✓
Minutes from previous meeting	✓	✓	✓	✓	✓	✓
Matters Arising & Table of Actions	✓	✓	✓	✓	✓	✓
Report of the Chair • Chair's Action • **Feedback from Board**	✓ ✓ ✓	✓ ✓ ✓	✓ ✓ ✓	✓ ✓ ✓	✓ ✓ ✓	✓ ✓ ✓
Report of the Lead Executive	✓	✓	✓	✓	✓	✓
Notification of Matters referred from other Board Committees on this or future agendas	#	#	#	#	#	#
Strategic Items for Decision – The Future						
Developing New Strategies or Plans						
Quality Elements of the Corporate Plan		✓	✓	✓		
Tier 1 Strategies for Board – to be defined in the corporate strategy (Living Healthier, Staying Well) • Quality Improvement Strategy • Clinical Strategy • Engagement Strategy • Health and Safety Strategy			 ✓ ✓	 ✓ ✓ 		
Tier 2 Strategies for committee approval – to be defined in the corporate strategy (Living Healthier, Staying Well) • Patient Experience Strategy • Safeguarding Strategy • Carers Strategy • Dementia Strategy • Mental Health Strategy		 ✓ 	 ✓	 ✓ ✓ ✓ 		
Agree Quality aspects of IMTP • Agree Annual Quality Plan - The Health and Social Care (Quality Engagement) (Wales) Act	✓ ✓					
Monitoring Existing Strategies or plans						
Corporate Strategy (Quality Monitoring Report)	Board		✓			✓
Quality aspects of IMTP • Annual Plan		✓ ✓		✓ ✓		✓ ✓

Agenda item	Mar	May	Jul	Sep	Nov	Jan
Monitoring Tier 1 Strategies on behalf of the Board – as defined in the corporate strategy) • Quality Improvement Strategy • Clinical Strategy • Engagement Strategy • Health and Safety Strategy	 ✓ ✓		 ✓ ✓	 ✓ ✓		 ✓ ✓
Monitoring Tier 2 Strategies for committee Approval – as defined in the corporate strategy) • Patient Experience Strategy • Safeguarding Strategy • Carers Strategy • Dementia Strategy • Mental Health Strategy	 ✓ ✓ ✓	 ✓	 ✓	 ✓ ✓ ✓	 ✓	 ✓
Other						
Endorse Quality Policies reserved for Board approval	#	#	#	#	#	#
Agree Quality Polices reserved for QSE approval	#	#	#	#	#	#
Policy status update including policies relevant reserved for Executive approval			✓			✓
Quality Safety and Performance – The Present						
Board Assurance Framework (relevant to QSE)		✓			✓	
Corporate Risk Register (relevant to QSE)	✓	✓	✓	✓	✓	✓
Directorate Operational Reports (incorporating seeing services from the front line) • **Mental Health** • **Primary and Community Care (including Continuing Health Care & Therapies)** • **Public Health** • **Secondary Care (Including North Wales Managed Services)** • ~~**Therapies**~~ • **Women's and Children's**	 ✓ ✓	 ✓ ✓	 ✓ ✓	 ✓ ✓	 ✓ ✓	 ✓ ✓
Integrated Performance Report (incorporating seeing services from the front line) • Quality (including numbers of incidents)	✓	✓	✓	✓	✓	✓
Deep Dive reports	✓		✓		✓	

Agenda item	Mar	May	Jul	Sep	Nov	Jan
• **Clinical Effectiveness (including Clinical Audit)** • **Patient Safety (including learning from incidents)** • **Patient Experience** • **Health and Safety** • **Safer Staffing**	✓	 ✓ ✓ ✓	✓	 ✓ ✓	✓ ✓	 ✓ ✓
Quality in partner or commissioned services • Welsh Health Specialised Services • Welsh Ambulance Services • Care Homes		✓		✓		✓
Prevention • Annual Flu planning and implementation • Immunisation report	✓ ✓			✓ ✓		
Assurance reports on Particular Areas of Concern – time limited	#	#	#	#	#	#
Annual Reports						
Committee Annual Report to Audit Committee	✓					
Review Committee Terms of Reference	✓					
Quality Annual Report		✓				
Putting things Right Annual Report		✓				
Safeguarding Annual Report			✓			
Infection Prevention and Control Annual Report			✓			
Accessible Healthcare Annual Report				✓		
Radiation Protection Annual Report				✓		
Tissue and Organ Donation Annual Report				✓		
Learning from – The Past						
Independent Assurance Reviews	#	#	#	#	#	#
Internal Assurance Reviews	#	#	#	#	#	#
Quality Improvement Team Annual Report	#	#	#	#	#	#
Health Inspectorate Wales Reports	#	#	#	#	#	#
Health Inspectorate Wales Annual BCU report			✓			
Public Ombudsman reports	#	#	#	#	#	#
Chairs Assurance Reports						
Chairs Assurance Reports from Strategic and Tactical Delivery Groups (for assurance)	✓	✓	✓	✓	✓	✓

Agenda item	Mar	May	Jul	Sep	Nov	Jan
• Executive Delivery Group - Quality Improvement • Patient Safety • Clinical Effectiveness Group • Health and Safety Group • Patient Experience Group	✓ ✓ ✓ ✓	✓ ✓ ✓ ✓	✓ ✓ ✓ ✓	✓ ✓ ✓ ✓	✓ ✓ ✓ ✓	✓ ✓ ✓ ✓
Chairs Assurance Reports (for information) • Executive Delivery Group – Transformation and Finance • Executive Delivery Group – People and Culture	✓ ✓	✓ ✓	✓ ✓	✓ ✓	✓ ✓	✓ ✓
Partnership meetings (for information) • Regional Partnership Board		✓			✓	
Advisory Groups (for information) • Health Care Professionals Forum • Local Partnership Forum • Stakeholder Reference Group	✓	✓	✓	✓	✓	✓
Other						
Closing Business						
Agree Items for referral to Board / Other committees	✓	✓	✓	✓	✓	✓
Review of Risks highlighted in the meeting for referral to Risk Management Group	✓	✓	✓	✓	✓	✓
Agree items for Chairs Assurance Report	✓	✓	✓	✓	✓	✓
Review of Meeting Effectiveness	✓	✓	✓	✓	✓	✓

Proposed Integrated Governance Framework

Executive Summary (to be incorporated within the master document)

This proposed Integrated Governance Framework covers a range of structural and behavioural issues and has been developed in partnership with the Executive Directors, committee chairs and Independent members and the wider BCUHB team.

The framework sets out the objectives and rationale and gives some worked examples and context. The proposals are relatively simple and designed to:

- Support the Board balance its responsibilities in relation to strategy, setting the culture and holding the organisation to account for the service it provides
- Improve the focus, co-ordination and relevance of Board and Committee papers with built in assurance levels
- Develop greater oversight of the People and Transformation agendas
- Give the Board assurance of delivery structures and lines of accountability
- Improve information flow, no orphan groups - improve the line of sight from Floor to Board through increased governance discipline

The changes are grouped into three main categories

Board structure - summarised in the organogram on page 14 which:

- Reduce the number of formal committees and sub committees from 9 to 7
    - 4 focused on culture and compliance / assurance
        - Audit
        - Charitable Funds
        - Remuneration & Terms of Service
        - Mental Helth Capacity and Compliance
    - 3 focussed on transformation, culture & assurance (including developing corporate and supporting strategies)
        - Performance, Finance and Information Governance
        - Quality Safety and Experience
        - Partnerships, People and Population Health
- Mainstream quality in Mental Health and Primary and Community Care in the Quality Safety and Experience Committee
- Improve visibility of the frontline for Board members

Changes to the **Delivery and assurance** model – figure 5 page 18

- The executive is the delivery arm of the board, and will head up Executive Delivery Groups for strategic delivery and Executive Director Management Teams for business as usual

- Board committees will be supported by these Executive groups and the Tactical Delivery Groups sitting underneath them – consistent across the structure; they will be able to do some of the heavy lifting for the committees
- the Strategic Tactical and Operational groups are replicable within the divisions to plug into the pan-BCU structure

Governance discipline

The operationalisation of the framework includes:

- Supporting sight **Floor to Board section 3.3.1.1 page 20**
    - Patient / staff stories at Board and Committees.
    - Directorate Reports at Board and Committee on a rotational basis covering challenges, celebrations, concerns and commendations.
    - Deep dive into areas programmed across the business year to give a depth of focus in a meeting rather than a shallow overview at every meeting.
    - This is in addition to the escalation and cascade process in within the Performance and Accountability Framework
- Groups relationships
    - Groups will be responsible for the effectiveness of sub-groups and their reporting to ensure no orphaned groups, and consistency of delivery actions through strategic, tactical and operational groups.
    - All groups to provide a Chairs Assurance Report as a route for matters to rise through the organisation as well as an audit trail and learning process for when they don't
- Agendas / Cycles of Business
    - Report of Lead Executive at Committees to make members aware of issues not suitable for a full paper.
    - Formal process to refer matters to other committees and receive matters from Board.
    - Identification of risks arising within a meeting for referral to the Risk Management Group.
    - Formal reporting (via the lead Executive) from formal partnership arrangements and advisory groups to appropriate committees.
    - Reviews of meeting effectiveness to capture learning and improvement.

Strategy Development and monitoring

- Proposal that the development of the Corporate Strategy is co-ordinated through PPPH but the QSE and PFIG own their relevant elements of the strategy.
- Proposal that the redeveloped Corporate Strategy identifies strategies for Board ownership (tier 1) and sub-strategies for Board information and committee ownership (tier 2). All strategies will be aligned to a Board Committee for ownership (where a strategy crosses the work of more than one committee the Board shall decide which committee takes primacy over the strategy).
- Inclusion of a tactical planning and strategy group for co-ordination and alignment of strategies

Audit Committee

Terms of Reference and Operating Arrangements

Red text = changes

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 Audit Committee is required by the Board, within the remit of the Committee to:

3.1.1.1. Provide evidenced based assurance that there is compliance with The Equalities Act 2010.

- In discharging its duty the Committee will have 'due regard' to the Public Sector Equality Duty, to eliminate discrimination, to advance equality of opportunities and foster good relations when carrying out all functions and day-to-day activities.
- In discharging its duty the Committee will have 'due regard' to the Socio-economic Duty, to consider how strategic decisions might help reduce the inequalities associated with socio-economic disadvantage.

3.1.1.2. Provide evidenced based assurance that BCUHB Policies are compliant with relevant legislation.

3.1.2. Provide evidence based and timely advice to the Board on developing strategies.

3.1.3. Provide evidence based and timely advice to the Board on the delivery of strategies including those relating to risk management.

3.1.4. Oversee and provide evidence based and timely advice to the Board on relevant risks and concerns.

3.1.5. Provide relevant evidence based and timely advice to the Board on:

3.1.5.1. Evidenced based and timely advice to the Board and the Accountable Officer on the assurance frameworks to support them in their decision taking and in discharging their accountabilities for securing the achievement of BCUHB's objectives.

3.1.5.2. Evidence based assurance to the Board and the Accountable Officer on whether effective arrangements are in place through the operation of the BCUHB's assurance framework.

3.1.5.3. Evidence based assurance to the Board and the Accountable Officer on the effectiveness of Risk Management, Performance Management and other areas as defined by the Board or Accountable officer from time to time.

3.1.6. Receive the results of relevant audits (clinical and non-clinical) and any other relevant investigations and provide the Board with evidence based impact assessment of the implementation of the recommendations.

3.2. The Audit Committee is authorised by the Board to:

3.2.1. 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:

3.2.1.1. the organisation's ability to achieve its objectives;

3.2.1.2. compliance with relevant regulatory requirements, standards, quality and delivery requirements and other directions and requirements set by the Welsh Government and others;

3.2.1.3. the reliability, integrity, safety and security of the information collected and used by the organisation;

3.2.1.4. the efficiency, effectiveness and economic use of resources; and

3.2.1.5. the extent to which the organisation safeguards and protects all its assets, including its people.

3.2.2. Ensure the provision of effective governance by reviewing

3.2.2.1. the Board's Standing Orders, and Standing Financial Instructions (including associated framework documents, as appropriate);

3.2.2.2. the effectiveness of the Board's Committees

3.2.2.3. 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;

3.2.2.4. the, Annual Audit Report and Structured Assessment

3.2.2.5. financial conformance and the Schedule of Losses and Compensation;

3.2.2.6. 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);

3.2.2.7. the adequacy of executive and managements responses to issues identified by audit, inspection, external reports and other assurance activity;

3.2.2.8. proposals for accessing Internal Audit services via Shared Service arrangements (where appropriate);

3.2.2.9. anti fraud policies, whistle-blowing processes and arrangements for special investigations; and

3.2.2.10. any particular matter or issue upon which the Board or the Accountable Officer may seek advice.

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

3.3.1. the adequacy of the Board Assurance Framework and Corporate Risk Register;

3.3.2. 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;

3.3.3. 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;

3.3.4. 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

3.3.5. 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;

3.3.6. regular tender waiver reports to ensure compliance with the Standing Financial Instructions.

3.4. 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.

3.5. 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:

3.5.1. 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

3.5.2. the reliability and integrity of these assurances.

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

3.6.1. 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;

3.6.2. 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;

3.6.3. 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;

3.6.4. 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;

3.6.5. 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;

3.6.6. 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;

3.6.7. 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 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.

4.2. 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::

4.2.1. Employee - and all employees are directed to cooperate with any legitimate request made by the Committee; and,

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

4.3. 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;

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

4.5. It will review risks from the Board Assurance Framework and 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**

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

6.1.2. The Chair of the Health Board shall not be a member of the Audit Committee.

6.2. **In attendance**

- Board Secretary (Lead Director).
- Executive Director of Finance
- Chief Executive.
- Deputy Chief Executive/Executive Director of Nursing and Midwifery.
- Director/Head of Governance
- Head of Internal Audit.
- Head/individual responsible for Clinical Audit.
- Local Counter Fraud Specialist.
- Representative of Auditor General (External Audit).

6.3. Right of Attendance

6.3.1. Upon giving notice to the Committee Chair the following have the right to attend any meeting as an observer:

- Chair of the Board.

6.4. **By Invitation**

- A patient representative.
- A staff representative.

6.4.1. Other Directors/Officers will attend as required by the Committee Chair, as well as any others from within or outside the organisation who the

Committee considers should attend, taking into account the matters under consideration at each meeting.

6.4.2. Trade Union Partners are welcome to attend the public session of the Committee

6.5. Member Appointments

6.5.1. The membership of the Committee shall be determined by the Chair 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.

6.5.2. 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 Chair of the Board. Independent Members may be reappointed up to a maximum period of 8 years.

6.6. Secretariat

6.6.1. The Secretariat will be determined by the Board Secretary.

6.7. Support to Group Members

6.7.1. 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 Secretray will also attend.

7.2. Frequency of Meetings

7.2.1. Meetings shall normally be held quarterly, but may be convened at short notice if requested by the Chair.

7.3. Withdrawal of individuals in attendance

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

7.4. Conduct of Meetings

7.4.1. Meetings may be held in person where it is safe to do so or by video-conferencing and similar technology.

7.4.2. 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.

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:

8.3.1.1. Joint planning and co-ordination of Board and Committee business; and

8.3.1.2. 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, and in doing and transacting its business shall seek assurance that adequate consideration has been given to the sustainable development principle and in meeting the requirements of the Well-Being of Future Generations Act.

8.5. Receive assurance and exception reports from

8.5.1.1. Risk Management Group.

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 and 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.

9.1.3. 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.

9.1.4. 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.

Version number 1.00	
Committee	**Date of approval**
Audit Committee	
Health Board	

Charitable Funds Committee

Terms of Reference and Operating Arrangements

Red text = changes

1. INTRODUCTION

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

2. PURPOSE

2.1. The Betsi Cadwaladr University Health Board (BCUHB) was appointed as the corporate trustee of the charitable funds by virtue of Statutory Instrument and its Board (acting as The Board of Trustees) serves as its agent in the administration of the charitable funds held by BCUHB.

2.2. The purpose of the Committee is to make and monitor arrangements for the control and management of BCUHB's Charitable Funds.

3. DELEGATED POWERS

3.1. The Charitable Funds Committee is required by the Board, within the remit of the Committee to:

3.1.1. Provide evidenced based assurance that there is compliance with:

- Provide evidenced based assurance that there is compliance with The Equalities Act 2010.
    - In discharging its duty the Committee will have 'due regard' to the Public Sector Equality Duty, to eliminate discrimination, to advance equality of opportunities and foster good relations when carrying out all functions and day-to-day activities.
    - In discharging its duty the Committee will have 'due regard' to the Socio-economic Duty, to consider how strategic decisions might help reduce the inequalities associated with socio-economic disadvantage.
- Provide evidenced based assurance that BCUHB Policies are compliant with relevant legislation.

3.1.2. Provide evidence based and timely advice to the Board on developing strategies.

3.1.3. Provide evidence based and timely advice to the Board on the delivery of strategies.

3.1.4. Oversee and provide evidence based and timely advice to the Board on relevant risks and concerns.

3.1.5. Receive the results of relevant audits (clinical and non-clinical) and any other relevant investigations and provide the Board with evidence based impact assessment of the implementation of the recommendations.

3.1.6. Within the budget, priorities and spending criteria determined by BCUHB as trustee and consistent with the requirements of the Charities Act 1993, Charities Act 2006 (or any modification of these acts) to apply the charitable funds in accordance with their respective governing documents, including the "Declaration of Trust" (Trust Deed).

3.1.7. To ensure that BCUHB policies and procedures for charitable funds investments are followed. To 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

3.1.8. To 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 BCUHB's investment adviser.

3.1.9. To oversee and monitor the functions performed by the Executive Director of Finance as defined in Standing Financial Instructions.

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

3.1.11. To monitor and review BCUHB'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.

3.1.12. To 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.

3.1.13. To keep the reserve policy under review to ensure that balances are not inappropriately retained.

3.1.14. To receive reports from the Chair of the Advisory Group at each Committee meeting for scrutiny and ratification.

3.1.15. To 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.

3.1.16. To receive, scrutinise and approve the Charity's Annual Report and Accounts on behalf of the Health Board.

3.2. The Charitable Funds Committee is authorised by the Board to seek assurance over the specific powers, duties and responsibilities delegated to the Executive Director of Finance namely to:

3.2.1. Administer of all existing charitable funds;

3.2.2. Identify any new charity that may be created (of which BCUHB is trustee) and to deal with any legal steps that may be required to formalise the trusts of any such charity;

3.2.3. Provide guidelines with respect to donations, legacies and bequests, fundraising and trading income;

3.2.4. Responsibility for the management of investment of funds held on Trust;

3.2.5. Ensure appropriate banking services are available to BCUHB;

3.2.6. Prepare reports to the BCUHB Board including the Annual Accounts and Annual report;

3.2.7. To monitor the balance of monies held within the Fund

3.2.8. To ensure that all expenditure (where appropriate) is ordered through the procurement process

4. AUTHORITY

4.1. The Committee is empowered with the responsibility for:-

4.1.1. 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 LHB's Standing Financial Instructions.

4.1.2. The appointment of an investment manager to advise it 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:

4.1.2..1. The scope of the power delegated is clearly set out in writing and communicated with the person or persons who will exercise it;

4.1.2..2. There are in place adequate internal controls and procedures which will ensure that the power is being exercised properly and prudently;

4.1.2..3. The performance of the person or persons exercising the delegated power is regularly reviewed;

4.1.2..4. Where an investment manager is appointed, that the person is regulated under the Financial Services Act 1986;

4.1.2..5. Acquisitions or disposal of a material nature must always have written authority of the Committee or the Chair of the Committee in conjunction with the Executive Director of Finance.

4.1.3. Ensuring that the banking arrangements for the charitable funds should be kept entirely distinct form the LHB's NHS funds.

4.1.4. Separate current and deposit accounts should be minimised consistent with meeting expenditure obligations.

4.1.5. The amount to be invested or redeemed from the sale of investments shall have regard to the requirements for immediate and future expenditure commitments.

4.1.6. The 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.

4.1.7. Obtaining appropriate professional advice to support its investment activities.

4.1.8. Regularly reviewing investments to see if other opportunities or investment managers offer a better return.

4.2. 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.

4.3. 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;

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

4.5. It will review risks from the Board Assurance Framework and 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.

5.1.1. The Committee shall establish and approve the Terms of Reference and Scheme of Delegation for a Charitable Funds Advisory Group to review specific funding applications.

6. MEMBERSHIP

6.1. **Members**

6.1.1. A minimum of seven (7) members of the committee comprising up to four (4) Independent Members, plus three (3) Executive Members

6.1.2. The Chair of the committee shall be an Independent Member of BCUHB.

6.1.3. Vice Chair of the committee shall be an Independent Member of BCUHB.

6.1.4. Executive members

- Executive Director of Finance (Lead Director)
- Executive Director of Planning and Performance
- Executive Medical Director

6.2. **In attendance**

- Charitable Funds Accountant
- Charitable Funds Fundraising Manager
- LHB Investment Advisor

6.3. Right of Attendance

6.3.1. Upon giving notice to the Committee Chair the following have the right to attend any meeting as an observer:

- Chair of the Board.
- Chair of the Audit Committee.
- Board Secretary.

6.4. **By Invitation**

- A patient representative.
- A staff representative.

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

6.4.3. Trade Union Partners are welcome to attend the public session of the Committee

6.5. Member Appointments

6.5.1. The membership of the Committee shall be determined by the Board of Trustees, based on the recommendation of the BCUHB 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. .

6.5.2. 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 Chair of the Board. Independent Members may be reappointed up to a maximum period of **8** years.

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

6.6. Secretariat

6.6.1. The Secretariat will be determined by the Board Secretary.

6.7. Support to Group Members

6.7.1. 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 three Members must be present to ensure the quorum of the Committee, two of whom should be Independent Members (including the Committee Chair or Vice-Chair) and one of whom should be an Executive Directors.

7.1.2. Independent Members must hold the majority of votes at a meeting:

7.1.2..1. Where there are an equal number of Independent Members and Executive Members, the Committee Chair shall cast a deciding vote in the event of a tied vote.

7.1.2..2. Where there are more Executive Members than Independent Members one or more Executive Members will relinquish their right to vote to create an equal number of Independent Members and Executive Members

7.2. Frequency of Meetings

7.2.1. Meetings shall normally be held quarterly, but may be convened at short notice if requested by the Chair.

7.3. Withdrawal of individuals in attendance

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

7.4. Conduct of Meetings

7.4.1. Meetings may be held in person where it is safe to do so or by video-conferencing and similar technology.

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

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

8.2. 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:

- Joint planning and co-ordination of Board and Committee business; and

- 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.

8.3. The Committee shall embed the corporate goals and priorities through the conduct of its business, and in doing and transacting its business shall seek assurance that adequate consideration has been given to the sustainable development principle and in meeting the requirements of the Well-Being of Future Generations Act.

8.4. Receive assurance and exception reports from

- Charitable Funds Advisory Group.

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 and 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.

9.1.3. 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 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.

Version number 1.00	
Committee	**Date of approval**
Charitable Funds Committee	
Audit Committee	
Health Board	

Mental Health and Capacity Compliance Committee

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

Terms of Reference and Operating Arrangements

Red text = changes

1. INTRODUCTION

1.1. The Board shall establish a committee to be known as Mental Health & Capacity Compliance Committee (MHCC). 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 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

3. DELEGATED POWERS

3.1. The Mental Health & Capacity Compliance Committee is required by the Board, within the remit of the Committee to:

3.1.1. Provide evidenced based assurance that there is compliance with The Equalities Act 2010.

- In discharging its duty the Committee will have 'due regard' to the Public Sector Equality Duty, to eliminate discrimination, to advance equality of opportunities and foster good relations when carrying out all functions and day-to-day activities.

- In discharging its duty the Committee will have 'due regard' to the Socio-economic Duty, to consider how strategic decisions might help reduce the inequalities associated with socio-economic disadvantage.

3.1.2. Provide evidenced based assurance that BCUHB Policies are compliant with relevant legislation.

3.1.3. Provide evidence based and timely advice to the Board on developing strategies.

3.1.4. Provide evidence based and timely advice to the Board on the delivery of strategies including those relating to Mental Health Act compliance.

3.1.5. Oversee and provide evidence based and timely advice to the Board on relevant risks and concerns.

3.1.6. Receive the results of relevant audits (clinical and non-clinical) and any other relevant investigations and provide the Board with evidence based impact assessment of the implementation of the recommendations.

3.2. The Mental Health & Capacity Compliance Committee is authorised by the Board to:

3.2.1. 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.

3.2.2. Identify matters of risk relating to Mental Health and Capacity legislation and seek assurance that such risks are being mitigated.

3.2.3. Monitor the use of the legislation and consider local trends and benchmarks.

3.2.4. Consider matters arising from the Hospital Managers' Power of Discharge Committee.

3.2.5. Ensure that all other relevant associated legislation is considered in relation to Mental Health and Capacity legislation.

3.2.6. Consider matters arising from visits undertaken by Healthcare Inspectorate Wales (HIW) Review Service for Mental Health in particular, issues relating to Mental Health Act 1983 and monitor action plans that inform responses to HIW reports [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.

3.2.7. Consider any reports made by the Public Services Ombudsman for Wales regarding complaints about Mental Health and Capacity legislation.

3.2.8. Receive and review reports on the approval for all Wales Approved Clinicians and Section 12(2) Doctors;

3.2.9. Consider and approve on behalf of the Board any 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.

3.2.10. Receive and review Depravation of :Liberty reports regarding authorisations and associated reasons;

3.2.11. Receive and review reports on the implementation of the Mental Health Measure and be satisfied that positive outcomes for people are being achieved.

3.2.12. 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.

3.2.13. 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.

3.2.14. Consider any other information, reports, etc. that the Committee deems appropriate.

3.2.15. Approve the appointment of Associate Hospital Managers.

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::

4.1.1. Employee - and all employees are directed to cooperate with any legitimate request made by the Committee; and,

4.1.2. 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 workforce, Partnerships and Population Health matters.

4.4. It will review risks from the Board Assurance Framework and 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.

5.2. 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 Group, terms of reference for which are attached as Annex 2.

5.3. 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).

5.4. 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 Group.

6. MEMBERSHIP

6.1. **Members**

6.1.1. A minimum of three Independent Members of the Board.

6.2. **In attendance**

- Executive Director of Public Health (Lead).
- Executive Director of Nursing and Midwifery.
- Executive Director of Primary Care and Community Services.
- Medical Director for Mental Health.
- Nursing Director for Mental Health.
- Mental Health Director.
- Mental Health Act Manager
- Service User Representative.
- Social Services Representative.
- North Wales Police Representative.
- Welsh Ambulance Services.
- IMCA Advocacy provider Representative.
- IMHA Advocacy provider Representative.
- Associate Director of Safeguarding (director lead for MCA team)
- Associate Director of Quality Assurance (director lead for MHA team)
- DoLS representative.

- Two Associate Hospital Managers (as nominated by the Power of Discharge Group) appointed for a period of four years with re-appointment not to exceed a maximum of eight years in total.

6.3. Right of Attendance

6.3.1. Upon giving notice to the Committee Chair the following have the right to attend any meeting as an observer:

- Chair of the Board.
- Chair of the Audit Committee.
- Board Secretary.

6.4. By Invitation

- A patient / Carer representative.
- A staff representative.

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

6.4.2. Trade Union Partners are welcome to attend the public session of the Committee

6.5. Member Appointments

6.5.1. The membership of the Committee shall be determined by the Chair 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.

6.5.2. 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 Chair of the Board. Independent Members may be reappointed up to a maximum period of 8 years.

6.6. Secretariat

6.6.1. The Secretariat will be determined by the Board Secretary.

6.7. Support to Group Members

6.7.1. 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 attend.

7.2. Frequency of Meetings

7.2.1. Meetings shall normally be held bi-monthly, but may be convened at short notice if requested by the Chair.

7.3. Withdrawal of individuals in attendance

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

7.4. Conduct of Meetings

7.4.1. Meetings may be held in person where it is safe to do so or by video-conferencing and similar technology.

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:

8.3.1.1. Joint planning and co-ordination of Board and Committee business; and

8.3.1.2. 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, and in doing and transacting its business shall seek assurance that adequate consideration has been given to the sustainable development principle and in meeting the requirements of the Well-Being of Future Generations Act.

8.5. Receive assurance and exception reports from

8.5.1.1. The Power of Discharge Group

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 and 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.

9.1.3. 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.

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.

Version number 1.00	
Committee	**Date of approval**
MHCC	
Audit Committee	
Health 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 In to 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.

Partnerships, People and Population Health Committee

Terms of Reference and Operating Arrangements

Red text = changes

1. INTRODUCTION

1.1. The Board shall establish a committee to be known as Partnerships, People and Population Health Committee (PPPH). 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 with regard to the development and oversight of the Health Board's enabling 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 the workforce strategies are aligned and that strategic collaboration and effective partnership arrangements are in place to improve population health and reduce health inequalities.

3. DELEGATED POWERS

3.1. The Partnerships, People and Population Health Committee is required by the Board, within the remit of the Committee to:

3.1.1. Provide evidenced based assurance that there is compliance with The Equalities Act 2010.

- In discharging its duty the Committee will have 'due regard' to the Public Sector Equality Duty, to eliminate discrimination, to advance equality of opportunities and foster good relations when carrying out all functions and day-to-day activities.

- In discharging its duty the Committee will have 'due regard' to the Socio-economic Duty, to consider how strategic decisions might help reduce the inequalities associated with socio-economic disadvantage.

3.1.2. Provide evidenced based assurance that BCUHB Policies are compliant with relevant legislation.

3.1.3. Provide evidence based and timely advice to the Board on developing strategies.

3.1.4. Provide evidence based and timely advice to the Board on the delivery of strategies including those relating to digital, workforce and transformation.

3.1.5. Oversee and provide evidence based and timely advice to the Board on relevant risks and concerns.

3.1.6. Provide relevant evidence based and timely advice to the Board on:

- Staffing matters
- Population health outcomes and prevention strategies.
- Transformation capacity delivery and planning.
- Delivery of the Corporate Strategy (improving outcomes for citizens), including in services delivered in partnership.

3.1.7. Receive the results of relevant audits (clinical and non-clinical) and any other relevant investigations and provide the Board with evidence based impact assessment of the implementation of the recommendations.

3.2. The Partnerships, People and Population Health Committee is authorised by the Board to:

3.2.1. 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.

3.2.2. Receive regular assurance reports on health and care clusters and primary care development, recognising the central role played by primary care in the delivery of health and care.

3.2.3. 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;

3.2.4. 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;

3.2.5. Receive regular performance and assurance reports from the Public Service Boards and Regional Partnership Board, Mental Health Partnership Board and other key partnerships as agreed by the Board.

3.2.6. Ensure that the Health Board meets its duties in relation to Welsh language, civil contingencies legislation and emergency preparedness.

3.2.7. 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 delivery plans;

3.2.8. 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 monitor sources of assurances in respect of partnership matters ensuring these are sufficiently detailed to allow for specific evaluations of effectiveness.

3.2.9. Ensure appropriate arrangements for continuous engagement are in place; and review assurances on Consultation feedback

3.2.10. Monitor performance against key workforce indicators as part of the Quality Report;

3.2.11. Receive 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.

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 workforce, Partnerships and Population Health matters.

4.4. It will review risks from the Board Assurance Framework and 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**

6.1.1. A minimum of three Independent Members of the Board.

6.2. **In attendance**

- Executive Director of Planning and Performance (Lead Director).
- Executive Director of Workforce and Organisational Development.
- Executive Director of Public Health.
- Executive Director Primary and Community Services.
- Executive Director of Therapies and Health Sciences.
- Executive Medical Director.
- Executive Director of Nursing and Midwifery.
- Finance Director – Strategy and Commissioning.

6.3. Right of Attendance

6.3.1. Upon giving notice to the Committee Chair the following have the right to attend any meeting as an observer:

- Chair of the Board.
- Chair of the Audit Committee.
- Board Secretary.

6.4. **By Invitation**

- A patient representative.
- Chair of Stakeholder Reference Group.
- A staff representative.

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

6.4.3. Trade Union Partners are welcome to attend the public session of the Committee

6.5. Member Appointments

6.5.1. The membership of the Committee shall be determined by the Chair 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.

6.5.2. 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 Chair of the Board. Independent Members may be reappointed up to a maximum period of 8 years.

6.6. Secretariat

6.6.1. The Secretariat will be determined by the Board Secretary.

6.7. Support to Group Members

6.7.1. 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 normally be held bi-monthly, but may be convened at short notice if requested by the Chair.

7.3. Withdrawal of individuals in attendance

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

7.4. Conduct of Meetings

7.4.1. Meetings may be held in person where it is safe to do so or by video-conferencing and similar technology.

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:

- Joint planning and co-ordination of Board and Committee business; and
- 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, and in doing and transacting its business shall seek assurance that adequate consideration has been given to the sustainable development principle and in meeting the requirements of the Well-Being of Future Generations Act.

8.5. Receive assurance and exception reports from

- Executive Delivery Group People and Culture
- Executive Delivery Group Transformation and Finance.
- Organisational Development Group.
- Population Health Group.

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 and 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.

9.1.3. 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.

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.

Version number 1.00	
Committee	**Date of approval**
PPPH	
Audit Committee	
Health Board	

Performance, Finance and Information Governance Committee

Terms of Reference and Operating Arrangements

Red text = changes
Green Text = imported from DIGC

1. INTRODUCTION

1.1. The Board shall establish a committee to be known as Performance, Finance and Information Governance Committee (PFIG). 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, performance and delivery, and information governance. This includes the Board's Capital Programme and Workforce activity costs.

3. DELEGATED POWERS

3.1. The Performance, Finance and Information Governance Committee is required by the Board, within the remit of the Committee to:

3.1.1. Provide evidenced based assurance that there is compliance with The Equalities Act 2010.

- In discharging its duty the Committee will have 'due regard' to the Public Sector Equality Duty, to eliminate discrimination, to advance equality of opportunities and foster good relations when carrying out all functions and day-to-day activities.

- In discharging its duty the Committee will have 'due regard' to the Socio-economic Duty, to consider how strategic decisions might help reduce the inequalities associated with socio-economic disadvantage.

3.1.2. Provide evidenced based assurance that BCUHB Policies are compliant with relevant legislation.

3.1.3. Provide evidence based and timely advice to the Board on developing strategies.

3.1.4. Provide evidence based and timely advice to the Board on the delivery of strategies including those relating to finance, performance and information governance.

3.1.5. Oversee and provide evidence based and timely advice to the Board on relevant risks and concerns.

3.1.6. Provide relevant evidence based and timely advice to the Board on:

3.1.6.1. The financial performance of the Health Board and developing the IMTP

3.1.6.2. The operational performance of the Hearth Board and associated Impact Improvement Plans.

3.1.6.3. Evidence based assurance on the financial position, forecasting, and the capital programme.

3.1.6.4. Evidence based assurance to the Board and accountable officer on whether effective arrangements are in place through the operation of the governance framework for data processing and information management

3.1.6.5. Development and oversight of finance and performance related strategies

3.1.7. Receive the results of relevant audits (clinical and non-clinical) and any other relevant investigations and provide the Board with evidence based impact assessment of the implementation of the recommendations.

3.2. The Performance, Finance and Information Governance Committee is authorised by the Board to:

Financial Management

3.2.1. Seek assurance on the Financial Planning process and consider Financial Plan proposals.

3.2.2. Monitor financial performance and cash management against revenue budgets and statutory duties.

3.2.3. 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.

3.2.4. Monitor turnaround and transformation programmes' progress and impact/pace of implementation of organisational savings plans.

3.2.5. Receive quarterly assurance reports arising from performance reviews, including performance and accountability reviews of individual directorates, divisions and sites.

3.2.6. To determine any new awards in respect of Primary Care contracts

Performance Management and accountability

3.2.7. Approve the Health Board's overall Performance Management Framework (to be reviewed on a three yearly basis or sooner if required).

3.2.8. Ensure detailed scrutiny of the performance and resources dimensions of the Quality and Performance Report (QAP);

3.2.9. Monitor performance and quality outcomes against Welsh Government targets including access times, efficiency measures and other performance improvement indicators, including local targets;

3.2.10. Review in year progress in implementing the financial and performance aspects of the Integrated Medium Term Plan (IMTP);

3.2.11. Review and monitor performance against external contracts

3.2.12. Receive assurance reports arising from Performance and Accountability Reviews of individual teams.

3.2.13. Receive assurance reports in respect of the Shared Services Partnership.

3.3. Capital Expenditure and Working Capital

3.3.1. Approve and monitor progress of the Capital Programme.

3.4. Workforce

~~3.4.1. Monitor performance against key workforce indicators as part of the QAP;~~

3.4.2. Monitor the financial aspects of workforce planning to meet service needs in line with agreed strategic plans.

~~3.4.3. Receive 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.~~

3.4.4. To consider and determine any proposals from the Primary Care Panel (via the Executive Team) in relation to whether the Health Board should take on responsibility for certain GP Practices.

3.5. Information Governance

3.5.1. Oversee the development of the Health Board's strategies and plans for maintaining the trust of patients and public through its arrangements for handling and using information, including personal information, safely and securely, consistent with the Board's overall strategic direction and any requirements and standards set for NHS bodies in Wales;

3.5.2. Oversee the direction and delivery of the Health Board's digital and information governance strategies to drive change and transformation in line with the Health Board's integrated medium term plan that will support modernisation using information and technology.

3.5.3. Consider the information governance and digital implications arising from the development of the Health Board's corporate strategies and plans or those of its stakeholders and partners;

3.5.4. Consider the information governance and digital implications for the Health Board of internal and external reviews and reports;

3.5.5. Oversee the development and implementation of a culture and process for data protection by design and default (including Privacy Impact Assessments) in line with legislation (e.g. General Data Protection Regulation).

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::

4.1.1. Employee - and all employees are directed to cooperate with any legitimate request made by the Committee; and,

4.1.2. 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.

4.4. It will review risks from the Board Assurance Framework and 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

6.1.1. A minimum of three Independent Members of the Board.

6.2. In attendance

- Executive Director of Finance / Senior Information Risk Owner (SIRO) (Lead Director).
- ~~Chief Executive~~
- Executive Medical Director / Caldicott Guardian
- ~~Executive Director of Workforce and Organisational Development~~
- Executive Director of Planning & Performance.
- Executive Director Nursing and Midwifery.
- Lead Director of Information Governance Department.
- Assistant Director Information Governance & Assurance/ Data Protection Officer (DPO).

6.3. Right of Attendance

6.3.1. Upon giving notice to the Committee Chair the following have the right to attend any meeting as an observer:

- Chair of the Board.
- Chair of the Audit Committee.
- Board Secretary.

6.4. By Invitation

- A patient representative.
- Chair of Stakeholder Reference Group
- A staff representative.

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

6.4.2. Trade Union Partners are welcome to attend the public session of the Committee

6.5. Member Appointments

6.5.1. The membership of the Committee shall be determined by the Chair 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.

6.5.2. 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 Chair of the Board. Independent Members may be reappointed up to a maximum period of 8 years.

6.6. Secretariat

6.6.1. The Secretariat will be determined by the Board Secretary.

6.7. Support to Group Members

6.7.1. 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 attend.

7.2. Frequency of Meetings

7.2.1. Meetings shall normally be held bi-monthly, but may be convened at short notice if requested by the Chair.

7.3. Withdrawal of individuals in attendance

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

7.4. Conduct of Meetings

7.4.1. Meetings may be held in person where it is safe to do so or by video-conferencing and similar technology.

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:

8.3.1.1. Joint planning and co-ordination of Board and Committee business; and

8.3.1.2. 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, and in doing and transacting its business shall seek assurance that adequate consideration has been given to the sustainable development principle and in meeting the requirements of the Well-Being of Future Generations Act.

8.5. Receive assurance and exception reports from

8.5.1.1. Executive Delivery Group Transformation and Finance.
8.5.1.2. Executive Delivery Group People and Culture
8.5.1.3. Capital Investment Group
8.5.1.4. Estates Group.

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 and 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.

9.1.3. 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.

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.

Version number 1.00	
Committee	**Date of approval**
PFIG	
Audit Committee	
Health Board	

Quality, Safety and Experience Committee

Terms of Reference and Operating Arrangements

Red text = changes

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 the quality of services including clinical effectiveness, patient safety and patient and carer experience whether delivered directly or through a partnership arrangement and health and safety issues.

3. DELEGATED POWERS

3.1. The Quality, Safety and Experience Committee is required by the Board, within the remit of the Committee to:

3.1.1. Provide evidenced based assurance that there is compliance with The Equalities Act 2010.

- In discharging its duty the Committee will have 'due regard' to the Public Sector Equality Duty, to eliminate discrimination, to advance equality of opportunities and foster good relations when carrying out all functions and day-to-day activities.

- In discharging its duty the Committee will have 'due regard' to the Socio-economic Duty, to consider how strategic decisions might help reduce the inequalities associated with socio-economic disadvantage.

3.1.2. Provide evidenced based assurance that there is compliance with The Health and Social Care (Quality and Engagement) (Wales) Act 2020.

- In discharging its duty the Committee will have 'due regard' to the duty of quality.

3.1.3. Provide evidenced based assurance that BCUHB Policies are compliant with relevant legislation.

3.1.4. Provide evidence based and timely advice to the Board on developing strategies.

3.1.5. Provide evidence based and timely advice to the Board on the delivery of strategies including quality, clinical effectiveness, patient safety and patient and carer experience.

3.1.6. Oversee and provide evidence based and timely advice to the Board on relevant risks and concerns.

3.1.7. Provide relevant evidence based and timely advice to the Board on quality of citizen centred health in relation to patient services, public health, health promotion and health protection including (but not limited to):

- Clinical effectiveness
- Patient Safety
- Patient and carer experience
- Safeguarding
- Health and Safety
- Infection, prevention and control

3.1.8. Receive the results of relevant audits (clinical and non-clinical) and any other relevant investigations and provide the Board with evidence based impact assessment of the implementation of the recommendations.

3.2. The Quality, Safety and Experience Committee is authorised by the Board to:

3.2.1. Seek assurance that outcomes for patients are delivered through partnership arrangements where that is beneficial for the patient.

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

3.2.3. Ensure the adequacy of safeguarding and infection, prevention and control arrangements.

3.2.4. 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.

3.2.5. Provide assurance in relation to improving clinical effectiveness and the safety of patients within the Health Board's services, as well as those provided by other organisations on behalf of the Health Board or as part of a partnership arrangement.

3.2.6. Seek assurance on the robustness and appropriateness of Health and Safety arrangements across the Health Board including aspects affecting patient care, quality and safety and experience.

3.2.7. 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'.

3.2.8. Receive assurances from the Quality Strategy ~~and Legislation Assurance Framework~~ to allow the Committee to review achievement against the Health and Care Standards including accessible health care to inform the Annual Quality and Annual Governance Statements.

3.2.9. 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).

3.2.10. Review and seek assurance on the appropriateness of the quality indicators defined within the Integrated Quality and Performance Report (IQPR) [tbc] and scrutinize the quality dimensions contained within the IQPR.

3.2.11. Review the sustainability of service provision across the Health Board in terms of quality of service, patient and carer experience and model of care provided.

3.2.12. Provide advice and assurance to the Board regarding the quality impact assessment of strategic plans as appropriate.

3.2.13. To receive periodic updates in respect of the workforce flu vaccination.

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, patient and carer experience matters.

4.4. It will review risks from the Board Assurance Framework and 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**

6.1.1. A minimum of three Independent Members of the Board.

6.2. **In attendance**

- Executive Director of Nursing and Midwifery (Lead Executive).
- Executive Medical Director.
- Executive Director of Therapies and Health Sciences.
- Executive Director of Primary Care & Community Services.
- Executive Director of Workforce & Organisational Development.
- Executive Director of Public Health.
- Director of Performance.
- Associate Director of Quality Assurance
- Director of Mental Health & Learning Disabilities.
- Senior Associate Medical Director.
- Chair of Healthcare Professionals Forum.
- Associate Board Member Representative of Community Health Council.

6.3. Right of Attendance

6.3.1. Upon giving notice to the Committee Chair the following have the right to attend any meeting as an observer:

- Chair of the Board.
- Chair of the Audit Committee.

- Board Secretary.

6.4. **By Invitation**

- A patient representative.
- A staff representative.
- Executive Director of Planning and Performance.

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

6.4.3. Trade Union Partners are welcome to attend the public session of the Committee

6.5. Member Appointments

6.5.1. The membership of the Committee shall be determined by the Chair 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.

6.5.2. 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 Chair of the Board. Independent Members may be reappointed up to a maximum period of 8 years.

6.6. Secretariat

6.6.1. The Secretariat will be determined by the Board Secretary.

6.7. Support to Group Members

6.7.1. 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 normally be held bi-monthly, but may be convened at short notice if requested by the Chair.

7.3. Withdrawal of individuals in attendance

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

7.4. Conduct of Meetings

7.4.1. Meetings may be held in person where it is safe to do so or by video-conferencing and similar technology.

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:

- Joint planning and co-ordination of Board and Committee business; and
- 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, and in doing and transacting its business shall seek assurance that adequate consideration has been given to the sustainable development principle and in meeting the requirements of the Well-Being of Future Generations Act.

8.5. Receive assurance and exception reports from

- Executive Delivery Group for Quality Improvement.
- Clinical Effectiveness Group.
- Patient and Carer Experience Group.
- Patient Safety and Quality Group.
- Health and Safety Group.
- Infection Protection and Control Group.

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 and 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.

9.1.3. 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 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.

Version number 1.00	
Committee	**Date of approval**
QSE	
Audit Committee	
Health Board	

Remuneration and Terms of Service Committee

Terms of Reference and Operating Arrangements

Red text = changes

1. INTRODUCTION

1.1. The Board shall establish a committee to be known as the Remuneration and Terms of Service Committee (RaTS). 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

2.1.1. 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;

2.1.2. 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

2.1.3. Specific functions as delegated by the Board and listed below.

3. DELEGATED POWERS

3.1. The Remuneration and Terms of Service Committee is required by the Board, within the remit of the Committee to:

3.1.1. Provide evidenced based assurance that there is compliance with The Equalities Act 2010.

- In discharging its duty the Committee will have 'due regard' to the Public Sector Equality Duty, to eliminate discrimination, to advance equality of opportunities and foster good relations when carrying out all functions and day-to-day activities.

- In discharging its duty the Committee will have 'due regard' to the Socio-economic Duty, to consider how strategic decisions might help reduce the inequalities associated with socio-economic disadvantage.

3.1.2. Provide evidenced based assurance that BCUHB Policies are compliant with relevant legislation.

3.1.3. Provide evidence based and timely advice to the Board on developing strategies.

3.1.4. Provide evidence based and timely advice to the Board on the delivery of strategies.

3.1.5. Oversee and provide evidence based and timely advice to the Board on relevant risks and concerns.

3.1.6. Receive the results of relevant audits (clinical and non-clinical) and any other relevant investigations and provide the Board with evidence based impact assessment of the implementation of the recommendations.

3.2. The Remuneration and Terms of Service Committee is authorised by the Board to:

3.2.1. 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;
- And to be sighted on the objectives set by the Chief Executive for his immediate team, confirm that Directors have had objectives set, and that appropriate and timely performance reviews have taken place
- 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

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

3.2.3. Monitor compliance with issues of professional registration, including the revalidation processes for medical and dental staff and registered nurses, midwifes and health visitors and registered professionals.

3.2.4. 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;

3.2.5. Consider and where appropriate, approve on behalf of the Board any policy within the remit of the Committee's business including approval of Workforce policies.

3.2.6. Consider reports on behalf of the Board giving an account of progress where any exclusion in respect of Upholding Professional Standards in Wales (UPSW) has lasted more than six months.

3.2.7. Consider reports on behalf of the Board giving an account of progress on performers list regulatory cases.

3.2.8. Consider reports on behalf of the Board on the position as regards whistleblowing and Safe haven.

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 Board Assurance Framework and 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**

6.1.1. A minimum of three Independent Members of the Board.

6.1.2. The Chair of the Audit Committee will be appointed to this Committee either as Vice-Chair or a member.

6.2. **In attendance**

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

6.2.1. Directors/Officers should leave the meeting when their personal remuneration or terms of service are being discussed.

6.3. Right of Attendance

6.3.1. Upon giving notice to the Committee Chair the following have the right to attend any meeting as an observer:

- Chair of the Board.
- Board Secretary.

6.4. **By Invitation**

- A staff representative.

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

6.4.2. Trade Union Partners are welcome to attend the public session of the Committee.

6.4.3. The Executive Director of Finance may be invited to attend as required, and will be consulted on any paper to be submitted to the Committee that may have financial implications.

6.5. Member Appointments

6.5.1. The membership of the Committee shall be determined by the Chair 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.

6.5.2. 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 Chair of the Board. Independent Members may be reappointed up to a maximum period of 8 years.

6.6. Secretariat

6.6.1. The Secretariat will be determined by the Board Secretary.

6.7. Support to Group Members

6.7.1. 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 normally be held bi-monthly, but may be convened at short notice if requested by the Chair.

7.3. Withdrawal of individuals in attendance

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

7.4. Conduct of Meetings

7.4.1. Meetings may be held in person where it is safe to do so or by video-conferencing and similar technology.

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:

- Joint planning and co-ordination of Board and Committee business; and

- 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, and in doing and transacting its business shall seek assurance that adequate consideration has been given to the sustainable development principle and in meeting the requirements of the Well-Being of Future Generations Act.

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 and 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.

9.1.3. 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 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.

Version number 1.00

Committee	Date of approval
RaTS	
Audit Committee	
Health Board	

Executive Leadership Team

Terms of Reference and Operating Arrangements

1. INTRODUCTION

1.1. The Accountable Officer shall establish a group and associated governance arrangements, to be known as the Executive Leadership Team (referred to throughout this document as 'ELT'). The detailed terms of reference and operating arrangements in respect of these meetings are set out below.

2. PURPOSE

2.1. The ELT is the executive decision making committee for BCUHB, chaired by the Chief Executive as the Accountable Officer.

2.2. The Accountable Officer is responsible for:

2.2.1. the overall organisation, management and staffing of the Health Board

2.2.2. its arrangements related to quality and safety of care

2.2.3. matters of finance,

2.2.4. any other aspect relevant to the conduct of the Health Board's business in pursuance of the strategic directions set by the Health Board's Board, and in accordance with its statutory responsibilities.

2.3. ELT is responsible for ensuring the effective operational management of the Health Board, enabling critical issues to be anticipated, discussed, action plans agreed and that there is appropriate integration, connection and liaison between individual services, clinical and corporate functions and between strategic and operational matters, and supporting the Chief Executive to discharge the responsibilities delegated to the Accountable Officer.

2.4. ELT will ensure the organisation remains fit for purpose by continuously reviewing effectiveness and efficiency of the organisational structure and support functions.

3. DELEGATED POWERS

3.1. The key responsibilities of the ELT are outlined below:

3.1.1. To provide the Board with advice and assurance concerning all aspects of setting and delivering the strategic direction for the Board, and the delivery of its associated strategies and plans;

3.1.1.1. Provide evidenced based assurance that there is compliance with The Equalities Act 2010.

- In discharging its duty the Group will have 'due regard' to the Public Sector Equality Duty, to eliminate discrimination, to advance equality of opportunities and foster good relations when

carrying out all functions and day-to-day activities.

- In discharging its duty the Group will have 'due regard' to the Socio-economic Duty, to consider how strategic decisions might help reduce the inequalities associated with socio-economic disadvantage.

3.1.1.2. Provide evidenced based assurance that BCUHB Policies are compliant with relevant legislation.

3.1.2. To support and advise the Board and its Committees in exercising their key functions namely:

- To set strategy
- To shape culture
- To assurance on performance and other matters
- To make decisions

3.1.3. To lead delivery of the Board's strategies and plans and national requirements;

3.1.4. To ensure effective operational management of the Health Board, enabling critical issues to be anticipated, discussed and action plans agreed;

3.1.5. To ensure that there is appropriate integration, connection and liaison between individual services, between clinical and corporate functions and between strategic and operational matters;

3.1.6. To ensure the organisation remains fit for purpose by continuously reviewing effectiveness and efficiency of the organisational structure and support functions;

3.1.7. To provide a forum for key policy areas to be debated and refined before they are discussed formally with the Board and/or responsible committees;

3.1.8. To support individual executive directors to deliver their delegated responsibilities by providing a forum for briefing, exchange of information, mutual support, resolution of issues and achievement of agreement;

3.1.9. To make management decisions on issues within the remit of the ELT, in-line with the Board's Scheme of Delegation.

3.2. With regard to the specific powers delegated to it by the Board, ELT's programme of work will include:

3.2.1. Leading and overseeing the delivery of the health board's performance against the National Outcomes Framework, the Integrated Medium Term Plan and related Annual Plan, and key local outcomes;

3.2.2. Taking forward actions arising from the Integrated Performance Report, agreeing and monitoring the delivery of Impact Improvement Plans where action is required to improve performance

3.2.3. Agreeing business cases for service developments and improvements

in line with the Scheme of Delegation agreed by the Board;

3.2.4. Reviewing the capital programme prior to consideration by Board Committee and approval by the Board;

3.2.5. Directing and monitoring the delivery of the health board's key strategies and plans prior to consideration by Board Committee and approval by the Board;

3.2.6. Monitoring financial performance to ensure that the health board's statutory duty is achieved;

3.2.7. Implementing and managing the structures, processes and responsibilities for identifying and managing the key risks facing the organisation; informing discussions at the Audit Committee, other Board Committees and the Board;

3.2.8. Keeping the operational effectiveness of policies and procedures under review; approval of policies not reserved to the Board or a committee of the Board;

3.2.9. Providing advice to the Committees of the Board and/or the Board on matters related to quality, safety, planning, commissioning, service level agreements and change management initiatives;

3.2.10. Ensuring staff are kept up to date on health board wide issues;

3.2.11. Acting as the forum in which Directors and senior managers can formally raise concerns and issues for discussion, making decisions on these issues;

3.2.12. Ensuring there is an effective business planning process in place.

4. AUTHORITY

4.1. ELT is authorised to investigate or have investigated any activity within its terms of reference. In doing so, ELT shall have the right to inspect any books, records or documents of the Health Board relevant to ELT's remit and ensuring patient/client and staff confidentiality, as appropriate.

4.2. ELT may seek any relevant information from any:

4.2.1. employee (and all employees are directed to cooperate with any reasonable request made by ELT); and

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

4.3. ELT 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;

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

4.5. ELT will review risks from the Corporate Risk Register and advise the Board on the appropriateness of the scoring and mitigating actions in place.

5. SUB-COMMITTEES

5.1. ELT may, subject to the approval of the Accountable Officer, establish sub groups to carry out on its behalf specific aspects of ELT business.

5.2. For 2021/22, ELT has established the following groups:

5.2.1. Executive Delivery Group - People and Culture

5.2.2. Executive Delivery Group - Quality Improvement

5.2.3. Executive Delivery Group - Transformation and Finance

5.2.4. Strategic Health & Safety Group – This Group, established in accordance with the Health and Safety at Work Act 1974, will keep under review measures taken to ensure compliance with health and safety legislation and responding policies and have the right to report matters of concern directly to the Board.

5.2.5. Performance Oversight Group

5.2.6. Risk Management Group

5.3. Other Groups may be established in response to emerging priorities throughout the year. ELT may form short life or task and finish groups to investigate or have investigated any activity (clinical and non-clinical) within its terms of reference.

6. MEMBERSHIP

6.1. Members

- Chief Executive (Chair)
- Deputy Chief Executive and Executive Director of Nursing & Midwifery (Vice Chair)
- Executive Medical Director
- Executive Director of Workforce and Organisational Development
- Executive Director of Planning and Performance
- Executive Director of Primary Care and Community Services
- Executive Director of Finance
- Executive Director of Therapies and Health Sciences
- Executive Director of Public Health

6.2. In attendance

- Board Secretary
- Interim Chief Operating Officer

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

6.4. Member Appointments

6.4.1. The membership of ELT shall be determined by the Accountable Officer to include all Executive Director Board Members of BCUHB and taking account of the balance of skills and expertise necessary to

deliver the ELT's remit and subject to any specific requirements or directions made by the Welsh Government.

6.5. Secretariat

6.5.1. The Chief Executive's Office will provide the secretariat for ELT.

6.6. Support to ELT Members

6.6.1. The Chief Executive's Office, on behalf of the ELT Chair, shall:

6.6.1.1. Arrange the provision of advice and support to ELT members on any aspect related to the conduct of their role; and

6.6.1.2. Ensure the provision of a programme of development for members as part of the overall Board Development program.

7. COMMITTEE MEETINGS

7.1. Quorum

7.1.1. At least five members must be present to ensure the quorum of ELT, one of whom must be the Chief Executive or Deputy Chief Executive.

7.1.2. Where members are unable to attend a meeting a nominated deputy may be asked to attend, at the discretion of the meeting's chair. Frequency of Meetings

7.2. Frequency of Meetings

7.2.1. The Chief Executive of shall determine the timing and frequency of meetings, which shall be routinely be held on a weekly basis.

7.3. Withdrawal of individuals in attendance

7.3.1. ELT 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 ELT, via the Chief Executive, 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. ELT is directly accountable to the Board for its performance in exercising the functions set out in these Terms of Reference,

8.3. ELT, 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 and in doing so contribute 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. ELT shall embed the Health Bboard's corporate standards, priorities and requirements across all aspects of BCUHB operations

8.5. ELT shall provide evidenced based assurance to the Board that there is compliance with (but not limited to):

8.5.1. National Health Service (Wales) Act 2006

8.5.2. The Health and Social Care (Quality and Engagement) (Wales) Act (2020)

8.5.3. The Equality Act 2010 (also known as the Public Sector Equality Duty or PSED)

8.5.4. The Human Rights Act 1998

8.5.5. The United Nations Convention on the Rights of People with Disabilities

8.5.6. BCUHB Policy

9. REPORTING AND ASSURANCE ARRANGEMENTS

9.1. The ELT Chair shall:

9.1.1. report formally, regularly and on a timely basis to the Board on ELT's activities. This includes regular verbal updates on activity, and the submission of ELT minutes and written reports where approriate;

9.1.2. bring to the Board's specific attention any significant matters under consideration by ELT;

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

9.1.4. The Board may also require the ELT Chair to report upon ELT's activities at public meetings, e.g. Annual General Meeting, or to community partners and other stakeholders, where this is considered appropriate;

9.1.5. The Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of ELT'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 BCUHB's Standing Orders are equally applicable to the operation of ELT, except in the following areas:

10.1.1. Quorum – 5 members

10.1.2. Issue of papers – 2 days prior to a meeting

10.1.3. Committee meetings will not be held in public - however, to ensure public accountability, the Chief Executive, as ELT Chair shall, report formally, regularly and on a timely basis to the Board on ELT's activities.

11. REVIEW

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

Power of Discharge Group

Terms of Reference and Operating Arrangements

Red text = changes

1. INTRODUCTION

1.1. The Mental Health & Capacity Compliance Committee shall establish the Power of Discharge Group. The detailed terms of reference and operating arrangements in respect of this Group are set out below.

2. PURPOSE

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

3. DELEGATED POWERS

3.1. The Power of Discharge Group is required by the Mental Health & Capacity Compliance Committee, within the remit of the Group to:

3.1.1. Provide evidenced based assurance that there is compliance with The Equalities Act 2010.

- In discharging its duty the Committee will have 'due regard' to the Public Sector Equality Duty, to eliminate discrimination, to advance equality of opportunities and foster good relations when carrying out all functions and day-to-day activities.

- In discharging its duty the Committee will have 'due regard' to the Socio-economic Duty, to consider how strategic decisions might help reduce the inequalities associated with socio-economic disadvantage.

3.1.2. Provide evidenced based assurance that BCUHB Policies are compliant with relevant legislation.

3.1.3. Oversee and provide evidence based and timely advice to the Mental Health Capacity and Compliance Committee on relevant risks and concerns.

3.1.4. Receive the results of relevant audits (clinical and non-clinical) and any other relevant investigations and provide the Mental Health Capacity and Compliance Committee with evidence based impact assessment of the implementation of the recommendations.

3.2. The Power of Discharge Group is authorised by the Mental Health & Capacity Compliance Committee to:

3.2.1. Comment specifically upon the processes employed by the Group'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.

3.2.2. 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 Group 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 Group.

3.2.3. The Group 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 Group shall have responsibility. Even so, Group 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. AUTHORITY

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

4.1.1. Employee - and all employees are directed to cooperate with any legitimate request made by the Group; and,

4.1.2. 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;

5. SUB-COMMITTEES

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

6. MEMBERSHIP

6.1. **Members**

- ~~Three Independent Members of the Board~~.
- A maximum of ten (10) appointed MHA Associate Hospital Manager (as nominated and agreed by the Mental Health Capacity and Compliance Committee) (Appointed for a period of four years with appointment not to exceed a maximum of eight years in total).

6.2. **In attendance**

- Director of Mental Health (Lead)
- Senior Mental Health Clinicians
- Associate Director of Quality Assurance (lead director for MHA)
- Mental Health Act Manager
- Officer Representatives for Learning Disabilities and Children's Services

6.3. Right of Attendance

6.3.1. Upon giving notice to the Committee Chair the following have the right to attend any meeting as an observer:

- Chair of the Board.
- Chair of the Audit Committee.
- Chair of the Mental Health & Capacity Compliance Committee.
- Board Secretary.

6.4. **By Invitation**

- A patient representative.
- A staff representative.

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

6.4.2. Trade Union Partners are welcome to attend the public session of the Group

6.5. Member Appointments

6.5.1. The membership of the Group shall be determined by the Chair of the Chair of the Mental Health & Capacity Compliance Committee account of the balance of skills and expertise necessary to deliver the Group'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 Group ~~who shall be Independent Members~~.

6.5.2. Appointed Associate Hospital Mangers shall hold office on the Group 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 Chair of the Mental Health & Capacity Compliance Committee. Associate Hospital Managers may be reappointed up to a maximum

period of 8 years.

6.6. Secretariat

6.6.1. The Secretariat will be determined by the Executive Director of Public Health.

6.7. Support to Group Members

6.7.1. The Executive Director of Public Health shall arrange the provision of advice and support to Group members on any aspect related to the conduct of their role and ensure the provision of a programme of development for Group members as part of the overall Board Development programme.

7. COMMITTEE MEETINGS

7.1. Quorum

7.1.1. At least two Associate Hospital Managers must be present to ensure the quorum of the Group, one of whom should be the Group Chair or Vice-Chair. In the interests of effective governance, it is expected that a minimum of two BCUHB Officers will also attend.

7.2. Frequency of Meetings

7.2.1. Meetings shall normally be held bi-monthly, but may be convened at short notice if requested by the Chair.

7.3. Withdrawal of individuals in attendance

7.3.1. The Group may ask any or all non-board members who would normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

7.4. Conduct of Meetings

7.4.1. Meetings may be held in person where it is safe to do so or by video-conferencing and similar technology.

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

8.1. Although the Mental Health & Capacity Compliance Committee has delegated authority to the Group 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 Group is directly accountable to the Mental Health & Capacity Compliance Committee for its performance in exercising the functions set out in these Terms of Reference,

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

8.3.1.1. Joint planning and co-ordination of Board and Committee business; and

8.3.1.2. 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 Group shall embed the corporate goals and priorities through the conduct of its business, and in doing and transacting its business shall seek assurance that adequate consideration has been given to the sustainable development principle and in meeting the requirements of the Well-Being of Future Generations Act.

9. REPORTING AND ASSURANCE ARRANGEMENTS

9.1. The Group Chair shall:

9.1.1. Report formally, regularly and on a timely basis to the Mental Health Capacity and Compliance Committee on the Group's activities via the Chair's assurance report and an annual report.

9.1.2. Ensure appropriate escalation arrangements are in place to alert the Chair of the Mental Health Capacity and Compliance Committee, Executive Director of Public Health or Chairs of other relevant committees of any urgent/critical matters that may affect the operation and/or reputation of the Health Board.

9.1.3. The Executive Director of Public Health shall oversee a process of regular and rigorous self-assessment and evaluation of the Group'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 Group, except in the following areas:

- Quorum
- Meeting in public (this Group will not routinely hold meetings in public)

- Rules regarding the timeframe for the availability of papers will not apply

11. REVIEW

11.1. These terms of reference and operating arrangements shall be reviewed annually by the Group and any changes recommended to the Mental Health Capacity and Compliance Committee for approval.

Version number 1.00	
Committee	**Date of approval**
PoDG	
MHCC	
Audit Committee	
Health Board	

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Committee / Meeting Name

Teitl yr Adroddiad

Report Title

Dyddiad:		**Date:**
Cyhoeddus neu Breifat:		**Public or private:**
Cyfarwyddwr Cyfrifol?:		**Accountable Director:**
Awdur yr Adroddiad:		**Report author:**
Craffu blaenorol:		**Prior scrutiny:**
Atodiadau		**Appendices:**

Argymhelliad?	**Recommendation(s)**

Translation required	**Report purpose**	
Ar gyfer Penderfyniad / cymeradwyaeth	✓	**For decision/ approval**
Ar gyfer Trafodaeth	✓	**For discussion**
Ar gyfer sicrwydd (translation)	✓ Choose an item.	**For assurance and level (0-3)[1]**
Er gwybodaeth	✓	**For information**

Translation required	**Annual Plan Priorities**
✓Choose an item.	

Translation required	**Annual Plan Enablers**
✓Choose an item.	

Translation required	**Targeted Improvement**
✓Choose an item.	

Translation required	**Link to Board Assurance Framework and Corporate Risk Register**

Translation required	*Insert reference numbers and title*	**Link to Tier 1 Corporate Risk Register**

Sefyllfa	**/ Situation**

Cefndir	**Background**

[1] Assurance levels: 0 no assurance 1- managerial oversight 2 – organisational oversight 3 – independent assurance

Asesiad	**Assessment & Analysis**
Translation required	**Strategic Alignment**
Translation required	**Engagement**
Translation required	**Other options considered**
Translation required	**Financial Implications**
Translation required	**Risk Analysis – Recommendations accepted or not**
Translation required	**Legal and Compliance**
Translation required	**Equality Impact Assessment - outcomes**
Translation required	**Public Sector Equality Duty**
Translation required	**Socio Economic Duty**
Optional but this section must be completed when a strategic decision is being or will be made by the Board, Board Committees or ET meetings	

Committee / Group Title

Agenda

xxday MM YYYY

Xx:xx to xx:xx

Venue : Microsoft Teams Meeting

Ref	Time	Agenda Item	Lead	Status & Enclosures
Governance				
		Opening Remarks	Chair	Verbal
		Apologies	Chair	Verbal
		Declarations of Interest	Chair	Verbal
		Minutes from the previous meeting	Chair	Paper
		Matters Arising & Table of Actions		Paper
		Report of the Chair • Chair's Action • Feedback from Board	Chair	n/a
		Report of the Lead Director	Chair/All	Paper / Verbal
		Notification of Matters referred from other Board Committees on this or future agendas		Verbal
Strategic Items for Decision – the future				
		e.g. Strategy in development		
		e.g. Strategies for approval		
		e.g. Monitoring of approved strategies		
		Board Assurance Framework & Corporate Risk Register		Paper
Quality, Safety and Performance – the present				

		Items referred by Board or other Committees		Paper / Verbal
		e.g. Quality / Performance reports		
		Assurance reports on Particular Areas of Concern – time limited		Paper
Learning from the past				
		e.g. HIW reports		
Chairs Assurance Reports				
		Chairs Assurance Reports (for Assurance or information) • Executive Delivery Group – Transformation and Finance • Executive Delivery Group – People and Culture • Executive Delivery Group - Quality Improvement		Paper
		Chairs Assurance Reports from Tactical Delivery Groups (for assurance)		Paper
		Chairs Assurance Reports from Stakeholder Groups (for information) • Health Care Professionals Forum • Local Partnership Forum • Stakeholder Reference Group		Paper
		Closing Business		
		Items to refer to Board / Other Committees		Verbal
		Agree items for Chair's Assurance Report to Board		Verbal
		Review of risks highlighted within the meeting		Verbal
		Review of meeting effectiveness	Vice-chair	Verbal
		Date & time of next meeting: Dd MM YYYY.	Chair	Verbal

Membership:

Quorum:

Committee / Group name

Chair's Assurance Report

Meeting date:	
Name of Chair:	
Responsible Director:	
Summary of business discussed:	
Key assurances provided at this meeting (including level of assurance 0-3):	•
Key risks including mitigating actions and milestones	•
Targeted Improvement Domain (s) addressed	• Mental Health (adult and children) * • Strategy, planning and performance * • Leadership (including governance, transformation and culture) * • Engagement (patients, public, staff and partners) * *delete as appropriate
Issues to be referred to another Committee	
Matters requiring escalation to the Board:	•
Well-being of Future Generations Act Sustainable Development Principle	*Describe how the items of business and the development of any proposals considered by the Committee gave adequate consideration to the sustainable development principles or if not indicate the reasons for this.* *1.Balancing short term need with long term planning for the future;* *2.Working together with other partners to deliver objectives;* *3. Involving those with an interest and seeking their views;* *4.Putting resources into preventing problems occurring or getting worse; and* *5.Considering impact on all well-being goals together and on other bodies)*
Socio Economic Duty	*Optional but this section must be completed when a strategic decision is being made at Board, committee and ET meetings*

Planned business for the next meeting:	Range of regular reports plus •
Date of next meeting:	

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

EQUALITY IMPACT ASSESSMENT FORMS

PARTS A (Screening – Forms 1-4) and

B (Key Findings and Actions – Form 5)

For:	*Proposed Integrated Governance Framework*
Date form completed:	*13.5.21*

PARTS A: SCREENING and B: KEY FINDINGS AND ACTIONS

Introduction:

These forms have been designed to enable you to record, and provide evidence of how you have considered the needs of all people (including service users, their carers and our staff) who may be affected by what you are writing or proposing, whether this is:

- a policy, protocol, guideline or other written control document;
- a strategy or other planning document e.g. your annual operating plan;
- any change to the way we deliver services e.g. a service review;
- a decision that is related to any of the above e.g. commissioning a new service or decommissioning an existing service.

Remember, the term 'policy' is used in a very broad sense to include "..all the ways in which an organisation carries out its business" so can include any or all of the above.

Assessing Impact

As part of the preparation for your assessment of impact, consideration should be given to the questions below.

You should also be prepared to consider whether there are possible impacts for subsections of different protected characteristic groups. For example, when considering disability, a visually impaired person will have a completely different experience than a person with a mental health issue.

It is increasingly recognised that discrimination can occur on the basis of more than one ground. People have multiple identities; we all have an age, a gender, a sexual orientation, a belief system and an ethnicity; many people have a religion and / or an impairment as well. The experience of black women, and the barriers they face, will be different to those a white woman faces. The elements of identity cannot be separated because they are not lived or experienced as separate. Think about:-

- ✓ How does your policy or proposal promote equality for people with protected characteristics (Please see the General Equality Duties)?
- ✓ What are the possible negative impacts on people in protected groups and those living in low-income households and how will you put things in place to reduce or remove these?
- ✓ What barriers, if any, do people who share protected characteristics face as a result of your policy or proposal? Can these barriers be reduced or removed?
- ✓ Consider sharing your EqIA wider within BCUHB (and beyond), e.g. ask colleagues to consider unintended impacts.
- ✓ How have you/will you use the information you have obtained from any research or other sources to identify potential (positive or negative) impacts?

Part A Form 1: Preparation

Please answer all questions

1.	What are you assessing i.e. what is the title of the document you are writing or the service review you are undertaking?	**Proposed Integrated Governance Framework**
2.	Provide a brief description, including the aims and objectives of what you are assessing.	*What is the Integrated Governance Framework trying to achieve?* *Organisational governance, culture and behaviour are inextricably linked. Colloquially governance can be described as "the way we do things around here"; culture can be described as "the way we do things around here – when no-one is watching". The proposed framework therefore needs to be supported by the Organisational Development Programme to address the behavioural and cultural issues raised by Board Members and the Welsh Government.* *The framework also needs to align to the emerging corporate strategy, as the framework is the delivery and assurance structure for the strategy.* *The framework aims to support the Board in its key functions of leading the Health Board to be effective and to deliver the principal role of a Health Board:* *To ensure the effective planning and delivery of healthcare for people for whom it is responsible, within a robust governance framework, to achieve the highest standards of patient safety and public service delivery, improve health, reduce inequalities and achieve the best possible outcomes for its citizens, and in a manner that promotes equality and human rights.*

Part A Form 1: Preparation

Please answer all questions

		The governance proposals are designed to meet the follow objectives agreed by the Board: Objective 1: • Ensure that the work of the Board and committees are pitched at the right level and balance their responsibilities in strategy, culture and accountability. Objective 2: • Develop a greater focus on strategy in committee – delivering for the future. Objective 3: • Improve the focus, co-ordination and relevance of Board and committee papers with built in assurance levels. Objective 4: • Give the Board clear line of sight over business as usual and strategic delivery structures, including lines of accountability to provide better assurance and reduce duplication. Objective 5: • Develop greater oversight of the People / Transformation agenda. Objective 6: • Improve information flow: no orphan groups - improve the line of sight from Floor to Board through increased governance discipline.

Part A Form 1: Preparation

Please answer all questions

3.	Who is responsible for whatever you are assessing – i.e. who has the authority to agree or approve any changes you identify are necessary?	The Health Board
4.	Is the Policy related to, or influenced by, other Policies or areas of work?	Proposed Equality Accountability Framework Maturity Matrices Guidance Document
5.	Who are the key Stakeholders i.e. who will be affected by your document or proposals? Has a plan for engagement been agreed?	All staff
6.	What might help or hinder the success of whatever you are doing, for example communication, training etc.?	Key risks from an Equality and Human Rights perspective can be broadly broken down in to two categories: - Consistency and line of sight - Diversity of thought and experience in leadership. Consistency and line of site concerns the consistent application of the principles of equality and human rights and compliance with the Public Sector Equality Duty "from Board to Ward". Clear direction, leadership, accountability and a consistent approach to audit and evidence are required in order to minimise this risk. Diversity of thought and experience in leadership concerns the quality and consistency of the application of the principles of Equality and Human Rights and compliance with the Public Sector Equality Duty. It is an evidenced and documented issue within the NHS that there is a lack of

Part A Form 1: Preparation

Please answer all questions

		diversity at Board and Senior Management level. there is also well documented evidence that a lack of diversity at board level poses a risk of lack of understanding of issues faced and solutions to those issues for people with protected characteristics. Evidence summarised in the Health Services Journal in 2019 showed that **boards of NHS organisation have become less diverse over the last 15 years.** There is strong evidence for the positive impact that diversity and equality in leadership has on organisational performance and culture. This is the case across the private, not-for-profit and public sectors. Diversity in leadership is important for the future of the NHS, particularly in light of the need to implement the new NHS long-term plan which promotes greater integration between staff and expresses the need for transformational change across health services. The percentage of chairs and non-executives of NHS trusts from a BME background has nearly halved in the last decade – from 15 per cent in April 2010 to 8 per cent today. The percentage of women in chair and non-executive roles has fallen from 47 per cent in 2002 to 38 per cent now. At the same time there has been no increase in the proportion of non-executive leaders with a disability – this has remained static, between 5 and 6 per cent.The problem with decreasing diversity on boards is particularly obvious in the NHS because it has a large proportion of female employees and BME staff who play key roles. T*he evidence for this much-needed change is clear: diversity and equality in leadership has a positive impact on organisational performance and culture. This is the case across the private, not-for-profit and public sectors.* Equality, diversity and inclusion leadership in the NHS is about having best practice in the governance of NHS organisations, better engagement with the staff which will lead to better

Part A Form 1: Preparation

Please answer all questions

		and significant improvements in the standards of care to patients delivered within its institutions.[1]
7.	Think about and capture the positive aspects of your policy that help to promote and advance equality by reducing inequality or disadvantage.	• the proposed framework proposes to Improve information flow: no orphan groups - improve the line of sight from Floor to Board through increased governance discipline. Equality and human rights are considered as part of the core function of the Health Board and this improvement in information flow is an opportunity to include our delivery of the Public Sector Equality Duty and the Socio-Economic Duty throughout the organisation, producing a more transparent, evidence based approach to eliminating discrimination and advancing equality. It provides an opportunity to align the new Equality Accountability Framework with the Performance Accountability Framework giving Board visibility of divisional delivery of our statutory equality duties.

[1] NHS is moving backwards in terms of board diversity | Comment | Health Service Journal (hsj.co.uk)

Part A Form 2: Record of potential Impacts - protected characteristics and other groups

Please answer all questions

Please complete the next section to show how this policy / proposal could have an impact (positive or negative) on the protected groups listed in the Equality Act 2010. It is important to note any opportunities you have identified that could advance or promote equality of opportunity. This includes identifying what we can do to remove barriers and improve participation for people who are under-represented or suffer disproportionate disadvantage.

Lack of evidence is not a reason for *not assessing equality impacts*. Please highlight any gaps in evidence that you have identified and explain how/if you intend to fill these gaps.

Remember to ask yourself this: If we do what we are proposing to do, in the way we are proposing to do it, will people who belong to one or more of each of the following groups be affected differently, compared to people who don't belong to those groups? For example, will they experience different outcomes, simply by reason of belonging to that/those group(s). And if so, will any different outcome put them at a disadvantage?

The sort of information/evidence that may help you decide whether particular groups are affected, and if so whether it is likely to be a positive or negative impact, could include (but is not limited to) the following:-

- population data
- information from EqIAs completed in other organisations
- staff and service users data, as applicable
- needs assessments
- engagement and involvement findings and how stakeholders have engaged in the development stages
- research and other reports e.g. Equality & Human Rights Commission, Office for National Statistics
- concerns and incidents
- patient experience feedback
- good practice guidelines
- participant (you and your colleagues) knowledge

Part A Form 2: Record of potential Impacts - protected characteristics and other groups

Please answer all questions

Protected characteristic or group	Will people in each of these protected characteristic groups be impacted by what is being proposed? If so is it positive or negative? (tick appropriate below) *for further direction on how to complete this section please click here training vid p13-18)*	Reasons for your decision (including evidence that has led you to decide this) A good starting point is the EHRC publication: "Is Wales Fairer (2018)?" You can also visit their website here	How will you reduce or remove any negative Impacts that you have identified?
	Guidance for Completion *In the columns to the left – and for each characteristic and each section here and below – make an assessment of how you believe people in this protected group may be affected by your policy or proposal, using information available to you and the views and expertise of those taking part in the assessment. This is your judgement based upon information available to you, including relevance and proportionality. If you answered 'Yes', you need to indicate if the potential impact will be positive or negative.* ***Please note it can be both e.g. a service moving to virtual clinics: disability (in the section below) re mobility issues could be positive, but for sensory issues a potential negative impact. Both would need to be considered and recorded.*** *The information that helps to inform the assessment should be listed in this column.* ***Please provide evidence for all answers.*** **Hint/tip: do not say: "not applicable", "no impact" or "regardless of…". If you have identified 'no impact' please explain clearly how you came to this decision.**		

Part A Form 2: Record of potential Impacts - protected characteristics and other groups

Please answer all questions

	NB: For all protected characteristics please ensure you consider issues around confidentiality, dignity and respect. **For the definitions of each characteristic please click here**					
	Yes	**No**	**(+ve)**	**(-ve)**		
Cross-characteristic issues	x		x	x	Embedding the principles of equality and human rights at heart of the Integrated Governance Framework enables and promotes compliance with the three aims of the Public Sector Equality Duty. The framework explicitly states that one of the core purposes of the Health Board is to reduce inequality and promote equality and human rights. The embedding of Equality and Inclusion within the framework is present, as the outline Terms of Reference include explicit reference to the Equality Act within *Commonality – Board Committees* *Commonality – Executive Delivery Groups.* There is a commitment for Tier 2 (Committee level strategies) to evidence Equality and Diversity principles. "When a strategy is presented to Board or committee, it should have a clear assurance paper attached to demonstrate a robust approach to Socio-economic and Equality Impact Assessment"	

Part A Form 2: Record of potential Impacts - protected characteristics and other groups

Please answer all questions

					The Strategic Tactical and Operational model makes clear the purpose of groups – it is positive that the Equality and Human Rights Strategic Forum is identified as a tactical group with a clear reporting line to the Partnership, People and Population Health Committee However, the consistent application of the principles may be at risk due to the lack of diversity in the demographics of the key components of the framework. the benefits of diversity at board level are well researched and evidence. A 2012 study by the NHS Leadership Academy found that having a more diverse board: • Creates a Board with shared values; and with an understanding and commitment about the role and importance of Equality, Diversity and Inclusion in commissioning and providing positive health outcomes, excellent patient experience for all and in working to reduce health inequalities. • Ensures that right from the start Equality, Diversity and Inclusion is built into the way of thinking and decision making with regards to the business of Board. • Places Equality, Diversity and Inclusion as a core value at the heart of the business of the Board.	Named protected characteristic leads at board level with a responsibility to understand and represent the specific issues faced by people with that protected characteristic. Board cover sheet strengthened board sheet to specifically request evidence of EqIA and SEIA Implementation of the proposed Equality Accountability Framework and integration of this framework with the Performance and Accountability Framework.

Part A Form 2: Record of potential Impacts - protected characteristics and other groups

Please answer all questions

					• Ensures the Board is equipped to address the business of reducing health inequalities and improving health outcomes for all patients, leading to improved quality and cost effective service delivery. Clearly the converse represents a significant risk, i.e. a lack of diversity at board level – and this is shown to be an NHS-wide issue – poses a risk to embedding equality, diversity and inclusion as a way of thinking and decision making with regards to the business of the board through a lack of diversity of thought and experience,.	Proactive recruitment strategies for Independent Member recruitment, advertising through third sector organisations.
Age	x		x	x	Section 3.1.1 states that "Board Committees can only have membership drawn from the Independent Members so as not to conflict Executive Members of the Board". There is a potential risk here as we know there is an issue across the UK of a lack of diversity at Board level – this will inevitably filter down in to a lack of diversity in the demographics of the committees. a 2018 report in to the make up of NHS Boards in England showed that Over 90% of NEDs (equivalent to an Independent Member) are aged 50 or above compared to just 65% of Executive Directors.[2]	Proactive recruitment strategies for Independent Member recruitment, advertising through third sector organisations. Consideration should be given to ensuring inclusive representation to reflect the diverse demographic of North Wales where possible, this should be included in the Terms of References, bu

[2] NHSI_board_membership_2017_survey_findings_Oct2018a_ig.pdf (england.nhs.uk), p26

Part A Form 2: Record of potential Impacts - protected characteristics and other groups

Please answer all questions

						invitation of oA patient representative, a staff representative, any other Executive Director.
Disability	x		x	x	Section 3.1.1 states that "Board Committees can only have membership drawn from the Independent Members so as not to conflict Executive Members of the Board". There is a potential risk here as we know there is an issue across the UK of a lack of diversity at Board level – this will inevitably filter down in to a lack of diversity in the demographics of	Proactive recruitment strategies for Independent Member recruitment, advertising through third sector organisations.

Part A Form 2: Record of potential Impacts - protected characteristics and other groups

Please answer all questions

					the committees. At an average of 5.3%, the proportion of disabled people on NHS provider boards is well below that of the general population (17.6%).[3] The documentation and communication of this framework could be inaccessible to people with sensory loss or neuro diversity.	Consideration should be given to ensuring inclusive representation to reflect the diverse demographic of North Wales where possible, this should be included in the Terms of References, bu invitation of oA patient representative, a staff representative, any other Executive Director The documentation and communication to be made available in a range of accessible formats.
Gender Reassignment	x		x	x	Section 3.1.1 states that "Board Committees can only have membership drawn from the Independent Members so as not to conflict Executive Members of the Board". There is a potential risk here as we know there is an issue across the	Proactive recruitment strategies for Independent Member recruitment,

[3] NHSI_board_membership_2017_survey_findings_Oct2018a_ig.pdf (england.nhs.uk), p27

Part A Form 2: Record of potential Impacts - protected characteristics and other groups

Please answer all questions

					UK of a lack of diversity at Board level – this will inevitably filter down in to a lack of diversity in the demographics of the committees.	advertising through third sector organisations. Consideration should be given to ensuring inclusive representation to reflect the diverse demographic of North Wales where possible, this should be included in the Terms of References, bu invitation of oA patient representative, a staff representative, any other Executive Director
Pregnancy and maternity	x		x	x	Section 3.1.1 states that "Board Committees can only have membership drawn from the Independent Members so as not to conflict Executive Members of the Board". There is a potential risk here as we know there is an issue across the UK of a lack of diversity at Board level – this will inevitably filter down in to a lack of diversity in the demographics of the committees.	Proactive recruitment strategies for Independent Member recruitment, advertising through third sector organisations. Consideration should be given to ensuring inclusive representation to reflect the diverse demographic of North Wales where possible, this should be included in the Terms of References, bu

Part A Form 2: Record of potential Impacts - protected characteristics and other groups

Please answer all questions

						invitation of oA patient representative, a staff representative, any other Executive Director
Race	x		x	x	Section 3.1.1 states that "Board Committees can only have membership drawn from the Independent Members so as not to conflict Executive Members of the Board". There is a potential risk here as we know there is an issue across the UK of a lack of diversity at Board level – this will inevitably filter down in to a lack of diversity in the demographics of the committees. The 2016 Workforce Race Equality Standards (WRES) report indicated that the proportion of ethnic minority staff in the NHS is 17.7%. The proportion of ethnic minority clinical very senior managers (VSM) is 7.9% (compared to 6.8% of ethnic minority EDs). The report also found that the only position on a Health Board where the % held by somebody identifying as an ethnic minority matches that of the NHS Workforce is Medical Director.[4] *The percentage of chairs and non-executives of NHS trusts from a BME background has nearly halved in the last decade – from 15 per cent in April 2010 to 8 per cent today*[5]	Proactive recruitment strategies for Independent Member recruitment, advertising through third sector organisations. Consideration should be given to ensuring inclusive representation to reflect the diverse demographic of North Wales where possible, this should be included in the Terms of References, bu invitation of oA patient representative, a staff representative, any other Executive Director

[4] NHSI_board_membership_2017_survey_findings_Oct2018a_ig.pdf (england.nhs.uk), p21-24

[5] NHS is moving backwards in terms of board diversity | Comment | Health Service Journal (hsj.co.uk)

Part A Form 2: Record of potential Impacts - protected characteristics and other groups

Please answer all questions

Religion, belief and non-belief	x		x	x	Section 3.1.1 states that "Board Committees can only have membership drawn from the Independent Members so as not to conflict Executive Members of the Board". There is a potential risk here as we know there is an issue across the UK of a lack of diversity at Board level – this will inevitably filter down in to a lack of diversity in the demographics of the committees. The range of faith of NHS provider board members broadly reflects that of the wider population, except that people of Muslim faith are under-represented.[6]	Proactive recruitment strategies for Independent Member recruitment, advertising through third sector organisations. Consideration should be given to ensuring inclusive representation to reflect the diverse demographic of North Wales where possible, this should be included in the Terms of References, bu invitation of oA patient representative, a staff representative, any other Executive Director
Sex	x		x	x	Section 3.1.1 states that "Board Committees can only have membership drawn from the Independent Members so as not to conflict Executive Members of the Board". There is a potential risk here as we know there is an issue across the UK of a lack of diversity at Board level – this will inevitably filter down in to a lack of diversity in the demographics of the committees. A 2018 report on NHS providers in	Proactive recruitment strategies for Independent Member recruitment, advertising through third sector organisations.

[6] NHSI_board_membership_2017_survey_findings_Oct2018a_ig.pdf (england.nhs.uk), p29

Part A Form 2: Record of potential Impacts - protected characteristics and other groups

Please answer all questions

					England showed that Of NHS provider boards 43% are women, whereas 77% of the NHS workforce are women.[7] It also showed that the greatest disparity between the representation of men and women on NHS provider boards is in the non-executive director cohort.	Consideration should be given to ensuring inclusive representation to reflect the diverse demographic of North Wales where possible, this should be included in the Terms of References, bu invitation of oA patient representative, a staff representative, any other Executive Director
Sexual orientation	x		x	x	Section 3.1.1 states that "Board Committees can only have membership drawn from the Independent Members so as not to conflict Executive Members of the Board". There is a potential risk here as we know there is an issue across the UK of a lack of diversity at Board level – this will inevitably filter down in to a lack of diversity in the demographics of the committees.	Proactive recruitment strategies for Independent Member recruitment, advertising through third sector organisations. Consideration should be given to ensuring inclusive representation to reflect the diverse demographic of North Wales where possible, this should be included in the Terms of References, bu invitation of oA patient

[7] NHSI_board_membership_2017_survey_findings_Oct2018a_ig.pdf (england.nhs.uk), p13

Part A Form 2: Record of potential Impacts - protected characteristics and other groups

Please answer all questions

						representative, a staff representative, any other Executive Director
Marriage and civil Partnership (Marital sctatus)						
Socio Economic Disadvantage	x		x	x	Section 3.1.1 states that "Board Committees can only have membership drawn from the Independent Members so as not to conflict Executive Members of the Board". There is a potential risk here as we know there is an issue across the UK of a lack of diversity at Board level – this will inevitably filter down in to a lack of diversity in the demographics of the committees.	Proactive recruitment strategies for Independent Member recruitment, advertising through third sector organisations. Consideration should be given to ensuring inclusive representation to reflect the diverse demographic of North Wales where possible, this should be included in the Terms of References, bu invitation of oA patient representative, a staff representative, any other Executive Director

Part A Form 2: Record of potential Impacts - protected characteristics and other groups

Please answer all questions

Part A Form 3: Record of Potential Impacts – Human Rights and Welsh Language

Please answer all questions

Human Rights:

Do you think that this policy will have a positive or negative impact on people's human rights? For more information on Human Rights, see our intranet pages at: http://howis.wales.nhs.uk/sitesplus/861/page/42166 and for additional information the Equality and Human Rights Commission (EHRC) Human Rights Treaty Tracker https://humanrightstracker.com.

The Articles (Rights) that may be particularly relevant to consider are:-

- *Article 2 Right to life*
- *Article 3 Prohibition of inhuman or degrading treatment*
- *Article 5 Right to liberty and security*
- *Article 8 Right to respect for family & private life*
- *Article 9 Freedom of thought, conscience & religion*

Please also consider these United Nations Conventions:

UN Convention on the Rights of the Child

UN Convention on the rights of people with disabilities.

UN Convention on the Elimination of All Forms of Discrimination against Women

Part A Form 3: Record of Potential Impacts – Human Rights and Welsh Language

Please answer all questions

Will people's Human Rights be impacted by what is being proposed? If so is it positive or negative? (tick as appropriate below)				**Which Human Rights do you think are potentially affected**	**Reasons for your decision (including evidence that has led you to decide this)**	**How will you reduce or remove any negative Impacts that you have identified?**
Yes	**No**	**(+ve)**	**(-ve)**			
						Please explain how you intend to remove or reduce any negative impacts you have identified. **Be specific.**

Part A Form 3: Record of Potential Impacts – Human Rights and Welsh Language

Please answer all questions

Welsh Language:

There are 2 key considerations to be made during the development of a policy, project, programme or service to ensure there are no adverse effects and / or a positive or increased positive effect on:

Welsh Language	**Will people be impacted by what is being proposed? If so is it positive or negative? (tick appropriate below)**				**Reasons for your decision (including evidence that has led you to decide this)**	**How will you reduce or remove any negative Impacts that you have identified?**
	Yes	**No**	**(+ve)**	**(-ve)**		
Opportunities for persons to use the Welsh language						*Please explain how you intend to remove or reduce any negative impacts you have identified.* ***Be specific.***
Treating the Welsh language no less favourably than the English language						*Please explain how you intend to remove or reduce any negative impacts you have identified.* ***Be specific.***

Part A Form 4: Record of Engagement and Consultation

Please answer all questions

Please record here details of any engagement and consultation you have undertaken. This may be with workplace colleagues or trade union representatives, or it may be with stakeholders and other members of the community including groups representing people with protected characteristics. They may have helped to develop your policy / proposal, or helped to identify ways of reducing or removing any negative impacts identified.

We have a legal duty to engage with people with protected characteristics under the Equality Act 2010. This is particularly important when considering proposals for changes in services that could impact upon vulnerable and/or disadvantaged people.

What steps have you taken to engage and consult with people who share protected characteristics and how have you done this? Consider engagement and participatory methods. *for further direction on how to complete this section please click here training vid p13-18)*	*Record here details of any engagement and consultation you have undertaken. This may be with workplace colleagues or trade union representatives, or it may be with stakeholders and other members of the community including groups representing people with protected characteristics. They may have helped to develop your policy / proposal, or helped to identify ways of reducing or removing any negative impacts identified.* *We have a legal duty to engage with people with protected characteristics under the Equality Act 2010. This is particularly important when considering proposals for changes in services that could impact upon people with protected characteristics.* *For further information and help, please contact the Corporate Engagement Team – see their intranet page at:-* *http://howis.wales.nhs.uk/sitesplus/861/page/44085*
Have any themes emerged? Describe them here.	*Describe here any information and/or themes that have emerged from your engagement. This could be any previously unidentified potential negative impacts identified by stakeholders or staff, or could be suggestions to strengthen positive equality impacts.*
If yes to above, how have their views influenced your work/guided your policy/proposal, or changed your recommendations?	*Describe any changes you have made to the policy/proposal due to feedback from your engagement and consultation.*

For further information and help, please contact the Corporate Engagement Team – see their intranet page at:- http://howis.wales.nhs.uk/sitesplus/861/page/44085

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

1. What has been assessed? (Copy from Form 1) *for further direction on how to complete this section please click here training vid p13-18)*	*Copy from Form 1*

2. Brief Aims and Objectives: (Copy from Form 1)	*Copy from Form 1*

From your assessment findings (Forms 2 and 3):

3a. Could any of the protected groups be negatively affected by your policy or proposal? **Guidance: This is as indicated on form 2 and 3**	Yes	No
3b. Could the impact of your policy or proposal be discriminatory under equality legislation? **Guidance: If you have completed this form correctly and reduced or mitigated any obstacles, you should be able to answer 'No' to this question.**	Yes	No

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

3c. Is your policy or proposal of high significance? **For example, does it mean changes across the whole population or Health Board, or only small numbers in one particular area?** High significance may mean: - The policy requires approval by the Health Board or subcommittee of - The policy involves using additional resources or removing resources. - Is it about a new service or closing of a service? - Are jobs potentially affected? - Does the decision cover the whole of North Wales - Decisions of a strategic nature: In general, strategic decisions will be those which effect how the relevant public body fulfils its intended statutory purpose (its functions in regards to the set of powers and duties that it uses to perform its remit) over a significant period of time and will not include routine 'day to day' decisions. GUIDANCE: If you have identified that your policy is of high significance and you have not fully removed all identified negative impacts, you may wish to consider sending your EqIA to the Equality Impact Assessment Scrutiny Group via the Equalities Team/	Yes	No

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

4. Did your assessment findings on Forms 2 & 3, coupled with your answers to the 3 questions above indicate that you need to proceed to a Full Impact Assessment?	Yes	No
	Record here the reason(s) for your decision i.e. what did Forms 2 & 3 indicate in terms of positive and negative impact for each characteristic, Human Rights and Welsh Language?	
5. If you answered 'no' above, are there any issues to be addressed e.g. reducing any identified minor negative impact?	Yes	
	Record Details: This will be a summary of any actions identified in the far right-hand column of forms 2 and 3.	
6. Are monitoring arrangements in place so that you can measure what actually happens after you implement your policy or proposal?	Yes	No
	How is it being monitored?	*What monitoring arrangements are to be used. By its very nature, an EqIA is an assessment of how people may be affected if we do what we are proposing to do. We therefore need to monitor actual outcomes compared to our assessment. This is not about creating new systems for monitoring but should use whatever systems are already in place. E.g. will you be using existing reports/data or do you need to gather your own information?* *Please describe how this will be built in to the policy document review process.*
	Who is responsible?	

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

	What information is being used?	*E.g. will you be using existing reports, data etc. or do you need to gather your own information? Liaising with engagement officer for stakeholder feedback.*
	When will the EqIA be reviewed?	*This will be the same date the policy, strategy, project or service change is reviewed*

7. Where will your policy or proposal be forwarded for approval?	*Usually a committee / group.* ***Please note it is not the role of the Equality team to approve your EqIA.***

8. Names of all parties involved in undertaking this Equality Impact Assessment – **please note EqIA should be undertaken as a group activity**	Name	Title/Role
	Names of people completing the EqIA. NB: this should ***not*** *be a lone individual.*	

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

Senior sign off prior to committee approval:	*Name of senior sign off prior to committee approval*	
Please Note: The Action Plan below forms an integral part of this Outcome Report		

Action Plan

This template details any actions that are planned following the completion of EqIA including those aimed at reducing or eliminating the effects of potential or actual negative impact identified.

	Proposed Actions **Please document all actions to be taken as a result of this impact assessment here. Be specific and use SMART actions. Please ensure these are built in to the policy, strategy, project or service change.**	Who is responsible for this action?	When will this be done by?
1. If the assessment indicates significant potential negative impact such that you cannot proceed, please give reasons and any alternative action(s) agreed:			
2. What changes are you proposing to make to your policy or proposal as a result of the EqIA?	*Please detail any changes you have made as a result of negative impacts identified. ,*		

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

	Proposed Actions **Please document all actions to be taken as a result of this impact assessment here. Be specific and use SMART actions. Please ensure these are built in to the policy, strategy, project or service change.**	Who is responsible for this action?	When will this be done by?
3a. Where negative impacts on certain groups have been identified, what actions are you taking or are proposed to reduce these impacts? Are these already in place?	*As indicated above, minor negative impact on one or two groups may well be an acceptable outcome. There may also be significant cost implications involved in removing minor impact for small groups but bear in mind that this minor impact could be 'disproportionate' to the group(s) involved.*		
3b. Where negative impacts on certain groups have been identified, and you are proceeding without reducing them, describe here why you believe this is justified.			
4. Provide details of any actions taken or planned to advance equality of opportunity as a result of this assessment.	*We have a specific legal duty to 'advance equality of opportunity' so record here anything you have discovered during your assessment that might contribute towards meeting this duty.*		

Cyfarfod a dyddiad: Meeting and date:	**Audit Committee**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Schedule of Closed Claims Over £50,000 - Quarter 4 2020/21
Cyfarwyddwr Cyfrifol: Responsible Director:	Executive Director of Nursing and Midwifery/Deputy CEO
Awdur yr Adroddiad Report Author:	Matthew Joyes, Acting Associate Director of Quality Assurance and Claims Managers
Craffu blaenorol: Prior Scrutiny:	Review by the Acting Associate Director of Quality Assurance
Atodiadau Appendices:	Schedule of closed claims and financial value for quarter three of 2020/21 (over £50,000)

Argymhelliad / Recommendation:

The Committee is asked to receive this report for assurance.

Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		**Ar gyfer Trafodaeth For Discussion**		**Ar gyfer sicrwydd For Assurance**	✓	**Er gwybodaeth For Information**	

Sefyllfa / Situation:

The attached report sets out total payment information for any claims against the Health Board with a spend of over £50,000 closed during Quarter 4 (January-March) of the 2020/21 financial year. This report formally summarises to the Audit Committee, the authorities given by the Health Board's Claims Managers, Executive Team and Board.

This report is presented to the Audit Committee to support the discharge of its responsibility to ensure the provision of effective governance.

The report includes two tables – one containing summary information for the public report and a more detailed tab for the private report which includes additional information that may be patient/staff identifiable.

Cefndir / Background:

All Health Boards in Wales contribute to a liability fund and have a risk share agreement, known as the Welsh Risk Pool (WRP).

The Health Board employs a team of Claims Managers who sit within the Patient Safety and Experience Department. These legally trained staff were recruited to strengthen the management of claims. Clinical negligence and personal injury claims are managed by the Health Board on the basis of legal advice provided

by the Legal and Risk Services Department of NHS Wales Shared Services Partnership. The Welsh Risk Pool will reimburse the Health Board for all losses incurred above an excess of £25,000 on a case by case basis.

To ensure that learning and improvement is commenced and implemented at the earliest possible stage the Welsh Risk Pool has amended its reimbursement procedures to bring the scrutiny of learning much earlier in the lifecycle of a case. These changes become effective from 1 October 2019. The WRP procedures introduce a Learning from Events Report (LfER) and a Case Management Report (CMR). These are used by the Health Board to report the issues that have been identified from a claim and to determine how these have been addressed in order to reduce the risk of reoccurrence and reduce the impact of a future event. The trigger for an LfER is related to the date of a decision to settle a case (even if the loss incurred is under £25,000) and the Health Board has sixty working days to submit a report from this date. A CMR is then submitted four months after the last payment on a claim is made, detailing how quantum was decided, if delegated authority was used and confirming that senior leaders have been advised of the claims. The LfER needs to provide a sufficient explanation of the circumstances and background to the events which have led to the case, in order for the WRP Committee to scrutinise and identify the links to the findings and learning outcomes. Supporting information, such as action plans, expert reports and review findings can be appended to the LfER to evidence the learning activity.

Should the Audit Committee require it, there is a learning document available for the cases listed within the schedule attached.

In all cases, claims have been managed by the Claims Managers within the Patient Safety and Experience Department who are all legally trained. All claims have been managed with the support and involvement of the Legal and Risk Services Department of NHS Wales Shared Services Partnership (NWSSP) and evidence of case management and learning has been, or will be, submitted to the Welsh Risk Pool.

The Quality, Safety and Experience Committee receives a separate quarterly Patient Safety Report to provide assurance on the learning and improvement following claims. This report to the Audit Committee provides assurance on the correct authorisation of payments as shown on the attached schedule for claims over £50,000.

Additionally, the Audit Committee is reminded that an annual internal audit of claims management is also undertaken which provides additional assurance on systems and process. The audit for 2020/21 has commenced.

Asesiad / Assessment & Analysis

Please see the attached schedule for detail of individual claims. The data provided has been taken from the Datix software system through which claims are managed.

Ref	Type	Region	Specialty	Incident Date	Total (Payment summary)
C17-2867	Clinical Negligence	BCUHB Central	General Surgery (Secondary)	17/11/2016	£ 80,544.30
CLA19-4043	Clinical Negligence	BCUHB East	General Surgery (Secondary)	19/04/2014	£ 65,130.00
E13-1058	Clinical Negligence	BCUHB East	Obstetrics (Secondary)	06/01/2009	£ 2,761,884.54
C13-1116	Clinical Negligence	BCUHB Central	General Surgery (Secondary)	22/09/2012	£ 390,556.82
E11-366	Clinical Negligence	BCUHB East	Paediatrics (Area)	06/07/2003	£ 2,602,636.95
W14-1772	Clinical Negligence	BCUHB West	General Surgery (Secondary)	29/07/2014	£ 104,302.58
W15-2060	Personal Injury	BCUHB West	Primary & Community Services (Area)	27/01/2015	£ 148,337.91
CLA16-2406	Personal Injury	BCUHB Central	Specialist Medicine (Secondary)	16/10/2015	£ 672,864.00
					£ 6,826,257.10