Devlin, Denise

From: Conlon, Bernie (IHRD)
Sent: 18 August 2016 09:42
To: Devlin, Denise
Subject: FW: Patient and Client Council
Attachments: Item 3-Board Composition.doc

Bernie Conlon
Secretary to Inquiry

From: Sean Brown [mailto:Sean.Brown@hscni.net]
Sent: 17 August 2016 14:56
To: Conlon, Bernie (IHRD)
Cc: Helen Mallen
Subject: Patient and Client Council

"This email is covered by the disclaimer found at the end of the message."

Bernie

Thanks for your e-mail of the 2nd August
In your e-mail you've asked a copy of PCC proposals submitted to the Department on the Board's composition and PCC proposals to include more service users.

Please see attached a copy of a paper discussed by Board members at a workshop on the 17th November 2015.
The paper was shared with the Department for information but no further work has been undertaken.
The Board did not make any proposals on how it could include more service users.

If you need any additional information please do not hesitate to contact me.

Sean Brown

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Patient and Client Council

Your voice in health and social care

PATIENT and CLIENT COUNCIL

Date: Board workshop 17 November 2015	**Paper No.** N/A	**Author:** Sean Brown
Title: Board Composition		

Category:	Decision	x	Information		Other:		Specify

Objective/Issue:

To provide the Board with a proposal on future size and make up, to inform future discussions on make-up of PCC.

Key points/Summary:

- Board size should be reduced to eight to ten members (including the Chair).
- All Board members should be appointed under the Public Appointments Process, based on merit and the necessary skill set;
- A mechanism should be found to strengthen service user focus.

The proposal and implementation is subject to DHSSPSNI approval and amending legislation.

Recommendation(s):

The Board are asked to discuss the key issues and determine the next steps so that we can provide a recommended Board structure for discussion with the DHSSPSNI.

Introduction

The main purpose of the Board of a public body is to provide effective leadership, direction, support and guidance to the organisation and to ensure that the organisation's statutory duties are met and the policies and priorities of the Minister (and the Northern Ireland Executive) are implemented.

The PCC Board Make up

The PCC is managed by a Board which has corporate responsibility for its operation. The Board of the PCC is made up of sixteen non-executive directors and a non-executive Chair. The non-executive directors include a Trade Union Representative Member, five Local Government Representative Members, five Community & Voluntary Sector Members and five Lay Members.

Board Members are appointed by the Minister under the Public Appointments process for an initial term of 4 years, with Ministerial discretion to reappointment for a second term of up to 4 years.

The Chief Executive, the Head of Development & Corporate Services and the Head of Operations of the PCC attend the board meetings but are not Members of the Board.

Although all Regional Bodies were invited to sit in attendance in 2009 only the Public Health Agency has taken up this offer.

Specific Role of PCC Board

The matters reserved to the Board of each HSC Organisation are derived from the **Code of Conduct and Code of Accountability** issued by the Health and Personal Social Services Management Executive.

Section 6 of the Code directs that:
"... Boards have six key functions for which they are held accountable by the Department of Health, Social Services and Public Safety on behalf of the Minister:

- Set strategic direction
- Monitoring performance
- Financial stewardship
- Corporate governance & personal behaviour and conduct
- Appointing, appraising senior officers and Non-Executive Directors
- Giving account to local communities

These responsibilities were stated and approved in the PCC Standing Orders approved on 1st April 2009.

Board skills required

The Public Appointments to the PCC have operated on the basis of the following selection and recruitment criteria:

- Making an impact with others and displays a range of political skills – *Developing and maintaining co-operative working relationships to achieve results. Displays range of political skills in networking with key stakeholders including local government*
- Committing to the non-executive role – *Understanding the working environment in which they are making a contribution*
- Thinking strategically – *Making a significant contribution to the strategic direction of the organisation*
- Analytical thinking – *Making decisions and solving problems in a team and organisational environment*
- Knowledge and understanding of the health, social care and public safety services in Northern Ireland – *Its purpose, structure, ethos and diversity*

All Members are appointed on the merit principle and must commit to the Nolan Principles on public life.

Previous PCC discussions on Board size

a) In its annual Self-Assessment exercise (February 2015) the Board noted the following when considering the " blend of Non- Executive Directors in its make up":
Whilst the Board meets this good practice requirement it has challenged itself on its size and composition, without compromising its core responsibilities.
The Board are also conscious of the Donaldson Report recommendation on increasing service user representation on the "Council".

b) In a meeting of Board Members on 9th March 2015 to discuss a response to Donaldson it was noted:
Maureen noted that the Board had already agreed in discussion that it should reduce in size.

The PCC Board would need options on Board structures for further discussion.

c) In its response to the Donaldson consultation (April 2015) the Board stated:
There are specific recommendations about the independence and composition of the PCC Board in the Report. The PCC has been considering the composition of the Board before the Donaldson report was published. The Board is very large, and we consider that a smaller number of members with the right skills can provide adequate governance for the organisation and fulfil our statutory responsibilities in this regard.

This work is underway and we will be submitting these proposals to the DHSSPSNI in due course.

d) A paper was submitted to the Governance and Audit Committee 2nd June 2015 with proposals on the Board size and composition. The Committee requested this be discussed by the full Board in a work shop session.

The following proposals are before the Board for consideration.

Board size

In its annual Self-Assessment exercise for 2015 the PCC Board agreed to consider its size in relation to its role. The role of the Board is quite explicit as outlined above. The size of the Board needs to be broad enough to encompass the skills to deliver on its key functions.

There is no definitive agreement on the ideal size of a Board but the PCC has previously discussed a reduction in its numbers. The Non-Executive make-up of the health and social care trusts and the Regional Health and Social Care Board numbers 7 Non-Executive Board members and a Chair.

Question: Is this a reasonable size for PCC Board assuming the right skill set? Form should follow function, so this needs to be related to what view the Board takes on representation and patient focus.

Representation

The current Board size and make up is very much reflective of the legacy organisations, the Health and Social Services Councils, which were representative bodies, providing opinion on health and social care issues, with no governance responsibilities.

It should be noted that the PCC Board is not a representative body. The legislation of the PCC states that in representing the views of people it must consult the public about matters relating to health and social care.

In its response to the Donaldson Review the Board made the following statement in relation to increased service user representation in the Council.

"The intent of the additional recommendation from Donaldson that more current or former service users should be on the Board is one that the PCC are largely in agreement with. However, that role should be in advising the Board and grounding us as we do our work on behalf of the public. We would like to consider this further and discuss it with service users and expert patients, many of whom already work with us. Some form of 'Advisory Board' or 'Panel of Active Patients' up-skilled as necessary to take a broader user perspective might work well. We consider that the role of service users in the governance of the organisation requires further consideration."

Question: do we consider that the Board should have reserved 'constituencies' for political representatives, V&C, lay etc. Or should it be open to all?

Proposal on Board Structure

1. It is proposed that the Non-Executive Board Members of the Patient and Client Council should be reduced to 8 to 10 in number, from the current 17. This would include the position of chair.
2. The Board should be made up of non-executive directors appointed under the public appointments process.
3. Potential Board Members should be considered lay candidates. The current defined allocation of positions to locally elected representatives, community and voluntary sector representatives and trade union representation should cease. This should not preclude representatives from these groupings applying to sit on the Board. Although exclusions should apply to other HSC bodies and regional organisations.
4. The Chair of the PCC would seek to ensure as far as possible that appointed Board Members would collectively hold the necessary skills to achieve the organisation's purpose. Those are likely to include knowledge on financial management, HR and management practices and health and social care, citizen representation and local government, as set out in the current appointments process.
5. The Board will meet formally in public 6-8 times a year to complete its core responsibilities. This would be agreed by the Board at its meeting in April each year.
6. The Board should focus on its key responsibilities, namely:
    a) Set Strategic Direction
    b) Monitoring Performance
    c) Financial Stewardship
    d) Corporate Governance & Personal Behaviour and Conduct
    e) Appointing, appraising Senior Officers and non- Executive Directors
    f) Giving account to Local Communities
7. The Board would continue to have a Governance and Audit Committee and a Research Advisory Committee.

Conclusion

The reduction in the size of the Board will allow better decision making focused on the core responsibilities of the Board. However given the reduction in the size of the Board and the increased demands on the contribution of Board Members a review of remuneration should also take place.