Department of Health
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BOARD GOVERNANCE SELF ASSESSMENT TOOL

For use by Department of Health Sponsored Arms Length Bodies

Trust Board 28th September 2023

Contents

Introduction

This self-assessment tool is intended to help Arm's Length Bodies (ALBs) improve the effectiveness of their Board and provide the Board members with assurance that it is conducting its business in accordance with best practice.

The public need to be confident that ALBs are efficient and delivering high quality services. The primary responsibility for ensuring that an ALB has an effective system of internal control and delivers on its functions; other statutory responsibilities; and the priorities, commitments, objectives, targets and other requirements communicated to it by the Department rests with the ALB's board. The board is the most senior group in the ALB and provides important oversight of how public money is spent.

It is widely recognised that good governance leads to good management, good performance, good stewardship of public money, good public engagement and, ultimately, good outcomes. Good governance is not judged by 'nothing going wrong'. Even in the best boards and organisations bad things happen and board effectiveness is demonstrated by the appropriateness of the response when difficulties arise.

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

This checklist has been developed by reviewing various governance tools already in use across the UK and the structure and format is based primarily on Department of Health governance tools. The checklist does not impose any new governance requirements on Department of Health sponsored ALBs.

The document sets out the structure, content and process for completing and independently validating a Board Governance Self-Assessment (the self-assessment) for Arms Length Bodies of the Department of Health.

The Self-Assessment should be completed by all ALB Boards and requires them to self-assess their current Board capacity and capability supported by appropriate evidence which may then be externally validated.

Application of the Board Governance Self-Assessment

It is recommended that all Board members of ALBs familiarise themselves with the structure, content and process for completing the self-assessment.

The self-assessment process is designed to provide assurance in relation to various leading indicators of Board governance and covers 4 key stages:

1. Complete the self-assessment
2. Approval of the self-assessment by the ALB Board and sign-off by the ALB Chair;
3. Report produced; and
4. Independent verification.

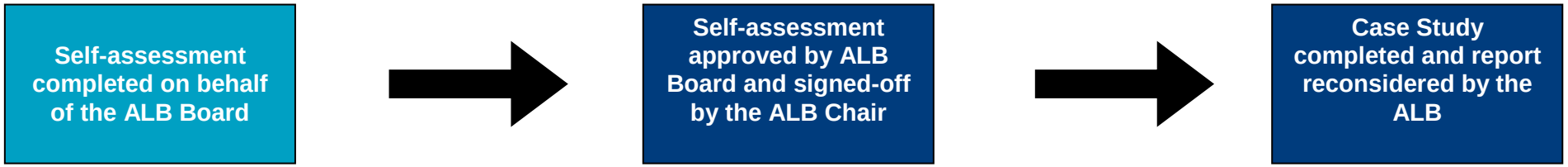
Complete the self-assessment: It is recommended that responsibility for completing the self-assessment sits with the Board and is completed section by section with identification of any key risks and good practice that the Board can evidence. The Board must collectively consider the evidence and reach a consensus on the ratings. The Chair of the Board will act as moderator. A submission document is attached for the Board to record its responses and evidence, and to capture its self-assessment rating.

Refer to the scoring criteria identified on page 7 to apply self assessment ratings.

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

Independent verification: The Board's ratings should be independently verified on average every three years. The views of the verifier should be provided in a report back to the Board. This report will include their independent view on the accuracy of the Board's ratings and where necessary, provide recommendations for improvement.

Overview



The Board Governance self-assessment is designed to provide assurance in relation to various leading indicators of effective Board governance. These indicators are:

1. Board composition and commitment (e.g. Balance of skills, knowledge and experience);

2. Board evaluation, development and learning (e.g. The Board has a development programme in place);

3. Board insight and foresight (e.g. Performance Reporting);

4. Board engagement and involvement (e.g. Communicating priorities and expectations);

5. Board impact case studies (e.g. A case study that describes how the Board has responded to a recent financial issue).

Each indicator is divided into various sections. Each section contains Board governance good practice statements and risks.

There are three steps to the completion of the Board Governance self-assessment tool.

Step 1

The Board is required to complete sections 1 to 4 of the self-assessment using the electronic Template. The Board should RAG rate each section based on the criteria outlined below. In addition, the Board should provide as much evidence and/or explanation as is required to support their rating. Evidence can be in the form of documentation that demonstrates that they comply with the good practice or Action Plans that describe how and when they will comply with the good practice. In a small number of instances, it is possible that a Board either cannot or may have decided not to adopt a particular practice. In cases like these the Board should explain why they have not adopted the practice or

cannot adopt the practice. The Board should also complete the Summary of Results template which includes identifying areas where additional training/guidance and/or assurance is required.

Step 2

In addition to the RAG rating and evidence described above, the Board is required to complete a minimum of 1 of 3 mini case studies on;

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

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

Step 3

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

Scoring Criteria

The scoring criteria for each section is as follows:

Green if the following applies:

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

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

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

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

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

Red if the following applies:

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

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

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

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

1. Board composition and commitment

1. Board composition and commitment overview

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

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

1. Board composition and commitment

1.1 Board positions and size

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

1. Board composition and commitment

1.2 Balance and calibre of Board members

Red Flag	Good Practice
1. There are no NEDs with a recent and relevant financial background. 2. There is no NED with current or recent (i.e. within the previous 2 years) experience in the private/ commercial sector. 3. The majority of Board members are in their first Board position. 4. The majority of Board members are new to the organisation (i.e. within their first 18 months). 5. The balance in numbers of Executives and Non Executives is incorrect. 6. There are insufficient numbers of Non Executives to be able to operate committees.	1. The Board can clearly explain why the current balance of skills, experience and knowledge amongst Board members is appropriate to effectively govern the ALB over the next 3-5 years. In particular, this includes consideration of the value that each NED will provide in helping the Board to effectively oversee the implementation of the ALB's business plan. 2. The Board has an appropriate blend of NEDs e.g. from the public, private and voluntary sectors. 3. The Board has had due regard under *Section 75 of the Northern Ireland Act 1998 to the need to promote equality of opportunity: between persons of different religious belief, political opinion, racial group, age, marital status or sexual orientation; between men and women generally; between persons with a disability and persons without; and between persons with dependants and persons without*. 4. There is at least one NED with a background specific to the business of the ALB. 5. Where appropriate, the Board includes people with relevant technical and professional expertise. 6. There is an appropriate balance between Board members (both Executive and NEDs) that are new to the Board (i.e. within their first 18 months) and those that have served on the Board for longer. 7. The majority of the Board are experienced Board members. 8. Where appropriate, the Chair of the Board has a demonstrable and recent track record of successfully leading a large and complex organisation, preferably in a regulated environment. 9. The Chair of the Board has previous non-executive experience. 10. At least one member of the Audit Committee has recent and relevant financial experience.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Board Skills audit • Biographical information on each member of the Board

1. Board composition and commitment

1.3 Role of the Board

Red Flag	Good Practice
1. The Chair looks constantly to the Chief Executive to speak or give a lead on issues. 2. The Board tends to focus on details and not on strategy and performance. 3. The Board become involved in operational areas. 4. The Board is unable to take a decision without the Chief Executive's recommendation. 5. The Board allows the Chief Executive to dictate the Agenda. 6. Regularly, one individual Board member dominates the debates or has an excessive influence on Board decision making.	1. The role and responsibilities of the Board have been clearly defined and communicated to all members. 2. Board members are clear about the Minister's policies and expectations for their ALBs and have a clearly defined set of objectives, strategy and remit. 3. There is a clear understanding of the roles of Executive officers and Non Executive Board members. 4. The Board takes collective responsibility for the performance of the ALB. 5. NEDs are independent of management. 6. The Chair has a positive relationship with the Minister and sponsor Department. 7. The Board holds management to account for its performance through purposeful, challenge and scrutiny. 8. The Board operates as an effective team. 9. The Board shares corporate responsibility for all decisions taken and makes decisions based on clear evidence. 10. Board members respect confidentiality and sensitive information. 11. The Board governs, Executives manage. 12. Individual Board members contribute fully to Board deliberations and exercise a healthy challenge function. 13. The Chair is a useful source of advice and guidance for Board members on any aspect of the Board. 14. The Chair leads meetings well, with a clear focus on the issues facing the ALB, and allows full and open discussions before major decisions are taken. 15. The Board considers the concerns and needs of all stakeholders and actively manages it's relationships with them.

	16. The Board is aware of and annually approves a scheme of delegation to its committees. 17. The Board is provided with timely and robust post-evaluation reviews on all major projects and programmes.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Terms of Reference • Board minutes • Job descriptions • Scheme of Delegation • Induction programme

1. Board composition and commitment

1.4 Committees of the Board

Red Flag	Good Practice
1. The Board notes the minutes of Committee meetings and reports, instead of discussing same. 2. Committee members do not receive performance management appraisals in relation to their Committee role. 3. There are no terms of reference for the Committee. 4. Non Executives are unaware of their differing roles between the Board and Committee. 5. The Agenda for Committee meetings is changed without proper discussion and/or at the behest of the Executive team.	1. Clear terms of reference are drawn up for each Committee including whether it has powers to make decisions or only make recommendations to the Board. 2. Certain tasks or functions are delegated to the Committee but the Board as a whole is aware that it carries the ultimate responsibility for the actions of its Committees. 3. Schemes of delegation from the Board to the Committees are in place. 4. There are clear lines of reporting and accountability in respect of each Committee back to the Board. 5. The Board agrees, with the Committees, what assurances it requires and when, to feed its annual business cycle. 6. The Board receives regular reports from the Committees which summarises the key issues as well as decisions or recommendations made. 7. The Board undertakes a formal and rigorous annual evaluation of the performance of its Committees. 8. It is clearly documented who is responsible for reporting back to the Board.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Scheme of delegation • TOR • Board minutes • Annual Evaluation Reports

1. Board composition and commitment

1.5 Board member commitment

Red Flag	Good Practice
1. There is a record of Board and Committee meetings not being quorate. 2. There is regular non-attendance by one or more Board members at Board or Committee meetings. 3. Attendance at the Board or Committee meetings is inconsistent (i.e. the same Board members do not consistently attend meetings). 4. There is evidence of Board members not behaving consistently with the behaviours expected of them and this remaining unresolved. 5. The Board or Committee has not achieved full attendance at at least one meeting within the last 12 months.	1. Board members have a good attendance record at all formal Board and Committee meetings and at Board events. 2. The Board has discussed the time commitment required for Board (including Committee) business and Board development, and Board members have committed to set aside this time. 3. Board members have received a copy of the Department's Code of Conduct and Code of Accountability for Board Members of Health and Social Care Bodies or the Northern Ireland Fire and Rescue Service. Compliance with the code is routinely monitored by the Chair. 4. Board meetings and Committee meetings are scheduled at least 6 months in advance.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Board attendance record • Induction programme • Board member annual appraisals • Board Schedule

2. Board evaluation, development and learning

2. Board evaluation, development and learning overview

This section focuses on Board evaluation, development and learning, and specifically the following areas:

1. Effective Board-level evaluation;

2. Whole Board Development Programme;

3. Board induction, succession and contingency planning;

4. Board member appraisal and personal development.

2. Board evaluation, development and learning

2.1 Effective Board level evaluation

Red Flag	Good Practice
1. No formal Board Governance Self-Assessment has been undertaken within the last 12 months. 2. The Board Governance Self-Assessment has not been independently evaluated within the last 3 years. 3. Where the Board has undertaken a self assessment, only the perspectives of Board members were considered and not those outside the Board (e.g. staff, etc). 4. Where the Board has undertaken a self assessment, only one evaluation method was used (e.g. only a survey of Board members was undertaken).	1. A formal Board Governance Self-Assessment has been conducted within the previous 12 months. 2. The Board can clearly identify a number of changes/ improvements in Board and Committee effectiveness as a result of the formal self assessments that have been undertaken. 3. The Board has had an independent evaluation of its effectiveness and the effectiveness of its committees within the last 3 years by a 3rd party that has a good track record in undertaking Board effectiveness evaluations. 4. In undertaking its self assessment, the Board has used an approach that includes various evaluation methods. In particular, the Board has considered the perspective of a representative sample of staff and key external stakeholders (e.g. commissioners, service users and clients) on whether or not they perceive the Board to be effective. 5. The focus of the self assessment included traditional 'hard' (e.g. Board information, governance structure) and 'soft' dimensions of effectiveness. In the case of the latter, the evaluation considered as a minimum: • The knowledge, experience and skills required to effectively govern the organisation and whether or not the Board's membership currently has this; • How effectively meetings of the Board are chaired; • The effectiveness of challenge provided by Board members; • Role clarity between the Chair and CE, Executive Directors and NEDs, between the Board and management and between the Board and its various committees; • Whether the Board's agenda is appropriately balanced between: strategy and current performance; finance and quality; making decisions and noting/ receiving information; matters internal to the organisation and external considerations; and business conducted at public board meetings and that done in confidential session. • The quality of relationships between Board members, including the Chair and CE. In particular, whether or not any one Board member has a tendency to dominate Board discussions and the level of mutual trust and respect between members.

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

2. Board evaluation, development and learning

2.2 Whole Board development programme

Red Flag	Good Practice
1. The Board does not currently have a Board development programme in place for both Executive and Non-Executive Board Members. 2. The Board Development Programme is not aligned to helping the Board comply with the requirements of the Management Statement and/or fulfil its statutory responsibilities.	1. The Board has a programme of development in place. The programme seeks to directly address the findings of the Board's annual self assessment and contains the following elements: understanding the relationship between the Minister, the Department and their organisation, e.g. as documented in the Management Statement; development specific to the business of their organisation; and reflecting on the effectiveness of the Board and its supporting governance arrangements. 2. Understanding the relationship between the Minister, Department and the ALB - Board members have an appreciation of the role of the Board and NEDs, and of the Department's expectations in relation to those roles and responsibilities. 3. Development specific to the ALB's governance arrangements – the Board is or has been engaged in the development of action plans to address governance issues arising from previous self-assessments/independent evaluations, Internal Audit reports, serious adverse incident reports and other significant control issues. 4. Reflecting on the effectiveness of the Board and its supporting governance arrangements -The development programme includes time for the Board as a whole to reflect upon, and where necessary improve: • The focus and balance of Board time; • The quality and value of the Board's contribution and added value to the delivery of the business of the ALB; • How the Board responded to any service, financial or governance failures; • Whether the Board's subcommittees are operating effectively and providing sufficient assurances to the Board; • The robustness of the ALB's risk management processes; • The reliability, validity and comprehensiveness of information received by the Board. 5. Time is 'protected' for undertaking this programme and it is well attended. 6. The Board has considered, at a high-level, the potential development needs of the Board to meet future challenges.
Examples of evidence that could be submitted to support the Board's RAG rating.	• The Board Development Programme • Attendance record at the Board Development Programme

2. Board evaluation, development and learning

2.3 Board induction, succession and contingency planning

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

2. Board evaluation, development and learning

2.4 Board member appraisal and personal development

Red Flag	Good Practice
1. There is not a robust performance appraisal process in place at Board level that includes consideration of the perspectives of other Board members on the quality of an individual's contribution (i.e. contributions of every member of the Board (including Executive Directors) on an annual basis and documents the process of formal feedback being given and received. 2. Individual Board members have not received any formal training or professional development relating to their Board role. 3. Appraisals are perceived to be a 'tick box' exercise. 4. The Chair does not consider the differing roles of Board members and Committee members.	1. The effectiveness of each Non-Executive Board member's contribution to the Board and corporate governance is formally evaluated on an annual basis by the Chair 2. The effectiveness of each Executive Board member's contribution to the Board and corporate governance is formally evaluated on an annual basis in accordance with the appraisal process prescribed by their organisation. 3. There is a comprehensive appraisal process in place to evaluate the effectiveness of the Chair of the Board that is led by the relevant Deputy Secretary (and countersigned by the Permanent Secretary). 4. Each Board member (including each Executive Director) has objectives specific to their Board role that are reviewed on an annual basis. 5. Each Board member has a Personal Development Plan that is directly relevant to the successful delivery of their Board role. 6. As a result of the Board member appraisal and personal development process, Board members can evidence improvements that they have made in the quality of their contributions at Board-level. 7. Where appropriate, Board members comply with the requirements of their respective professional bodies in relation to continuing professional development and/or certification.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Performance appraisal process used by the Board • Personal Development Plans • Board member objectives • Evidence of attendance at training events and conferences • Board minutes that evidence Executive Directors contributing outside their functional role and challenging other Executive Directors.

3. Board insight and foresight

3. Board insight and foresight overview

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

1.Board Performance Reporting

2.Efficiency and productivity

3.Environmental and strategic focus

4.Quality of Board papers and timeliness of information

3. Board insight and foresight

3.1 Board performance reporting

Red Flag	Good Practice
1. Significant unplanned variances in performance have occurred. 2. Performance failures were brought to the Board's attention by an external party and/or not in a timely manner. 3. Finance and Quality reports are considered in isolation from one another. 4. The Board does not have an action log. 5. Key risks are not reported/escalated up to the Board.	1. The Board has debated and agreed a set of quality and financial performance indicators that are relevant to the Board given the context within which it is operating and what it is trying to achieve. Indicators should relate to priorities, objectives, targets and requirements set by the Dept. 2. The Board receives a performance report which is readily understandable for all members and includes: • performance of the ALB against a range of performance measures including quality, performance, activity and finance and enables links to be made; • Variances from plan are clearly highlighted and explained ; • Key trends and findings are outlined and commented on ; • Future performance is projected and associated risks and mitigating measures; • Key quality information is triangulated (e.g. complaints, standards, Dept targets, serious adverse incidents, limited audit assurance) so that Board members can accurately describe where problematic services lines are ;Benchmarking of performance to comparable organisations is included where possible. 3. The Board receives a brief verbal update on key issues arising from each Committee meeting from the relevant Chair. This is supported by a written summary of key items discussed by the Committee and decisions made. 4. The Board regularly discusses the key risks facing the ALB and the plans in place to manage or mitigate them. 5. An action log is taken at Board meetings. Accountable individuals and challenging/demanding timelines are assigned. Progress against actions is actively monitored. Slips in timelines are clearly identifiable through the action log and individuals are held to account.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Board Performance Report • Board Action Log • Example Board agendas and minutes highlighting committee discussions by the Board.

3. Board insight and foresight

3.2 Efficiency and Productivity

Red Flag	Good Practice
1. The Board does not receive performance information relating to progress against efficiency and productivity plans. 2. There is no process currently in place to prospectively assess the risk(s) to quality of services presented by efficiency and productivity plans. 3. Efficiency plans are based on a percentage reduction across all services rather than a properly targeted assessment of need. 4. The Board does not have a Board Assurance Framework (BAF).	1. The Board is assured that there is a robust process for prospectively assessing the risk(s) to quality of services and the potential knock-on impact on the wider health and social care community of implementing efficiency and productivity plans. 2. The Board can provide examples of efficiency and productivity plans that have been rejected or significantly modified due to their potential impact on quality of service. 3. The Board receives information on all efficiency and productivity plans on a regular basis**.** Schemes are allocated to Directors and are RAG rated to highlight where performance is not in line with plan. The risk(s) to non-achievement is clearly stated and contingency measures are articulated. 4. There is a process in place to monitor the ongoing risks to service delivery for each plan, including a programme of formal post implementation reviews.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Efficiency and Productivity plans • Reports to the Board on the plans • Post implementation reviews

3. Board insight and foresight

3.3 Environmental and strategic focus

Red Flag	Good Practice
1. The Board does not have a clear understanding of Executive/Departmental priorities and its statutory responsibilities, business plan etc. 2. The Board's annual programme of work does not set aside time for the Board to consider environmental and strategic risks to the ALB. 3. The Board does not formally review progress towards delivering its strategies.	1. The Chief Executive presents a report to every Board meeting detailing important changes or issues in the external environment (e.g. policy changes, quality and financial risks). The impact on strategic direction is debated and, where relevant, updates are made to the ALB's risk registers and Board Assurance Framework (BAF). 2. The Board has reviewed lessons learned from SAIs, reports on discharge of statutory responsibilities, negative reports from independent regulators etc and has considered the impact upon them. Actions arising from this exercise are captured and progress is followed up. 3. The Board has conducted or updated an analysis of the ALB's performance within the last year to inform the development of the Business Plan. 4. The Board has agreed a set of corporate objectives and associated milestones that enable the Board to monitor progress against implementing its vision and strategy for the ALB. Performance against these corporate objectives and milestones are reported to the board on a quarterly basis. 5. The Board's annual programme of work sets aside time for the Board to consider environmental and strategic risks to the ALB. Strategic risks to the ALB are actively monitored through the Board Assurance Framework (BAF).
Examples of evidence that could be submitted to support the Board's RAG rating.	• CE report • Evidence of the Board reviewing lessons learnt in relation to enquiries • Outcomes of an external stakeholder mapping exercise • Corporate objectives and associated milestones and how these are monitored • Board Annual programme of work • BAF • Risk register

3. Board insight and foresight

3.4 Quality of Board papers and timeliness of information

Red Flag	Good Practice
1. Board members do not have the opportunity to read papers e.g. reports are regularly tabled on the day of the Board meeting and members do not have the opportunity to review or read prior to the meeting. The volume of papers is impractical for proper reviewing. 2. Board discussions are focused on understanding the Board papers as opposed to making decisions. 3. The Board does not routinely receive assurances in relation to Data Quality or where reports are received, they have highlighted material concerns in the quality of data reporting. 4. Information presented to the Board lacks clarity, or relevance; is inaccurate or untimely; or is presented without a clear purpose, e.g. is it for noting, discussion or decision. 5. The Board does not discuss or challenge the quality of the information presented or, scrutiny and challenge is only applied to certain types of information of which the Board have knowledge and/or experience, e.g. financial information	1. The Board can demonstrate that it has actively considered the timing of the Board and Committee meetings and presentation of Board and Committee papers in relation to month and year end procedures and key dates to ensure that information presented is as up-to-date as possible and that the Board is reviewing information and making decisions at the right time. 2. A timetable for sending out papers to members is in place and adhered to. 3. Each paper clearly states what the Board is being asked to do (e.g. noting, approving, decision, and discussion). 4. Board members have access to reports to demonstrate performance against key objectives and there is a defined procedure for bringing significant issues to the Board's attention outside of formal meetings. 5. Board papers outline the decisions or proposals that Executive Directors have made or propose. This is supported; where appropriate, by: an appraisal of the relevant alternative options; the rationale for choosing the preferred option; and a clear outline of the process undertaken to arrive at the preferred option, including the degree of scrutiny that the paper has been through. 6. The Board is routinely provided with data quality updates. These updates include external assurance reports that data quality is being upheld in practice and are underpinned by a programme of clinical and/or internal audit to test the controls that are in place. 7. The Board can provide examples of where it has explored the underlying data quality of performance measures. This ensures that the data used to rate performance is of sufficient quality. 8. The Board has defined the information it requires to enable effective oversight and control of the organisation, and the standards to which that information should be collected and quality assured.

	9. Board members can demonstrate that they understand the information presented to them, including how that information was collected and quality assured, and any limitations that this may impose. 10. Any documentation being presented complies with Departmental guidance, where appropriate e.g. business cases, implementation plans.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Documented information requirements • Data quality assurance process • Evidence of challenge e.g. from Board minutes • Board meeting timetable • Process for submitting and issuing Board papers • In-month reports • Board papers • Data Quality updates

3. Board insight and foresight

3.5 Assurance and risk management

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

4. Board engagement and involvement

4. Board engagement and involvement overview

This section focuses on Board engagement and involvement, and specifically the following areas:

1.External Stakeholders

2.Internal Stakeholders

3.Board profile and visibility

4. Board engagement and involvement

4.1 External stakeholders

The statutory duty of involvement and consultation commits ALBs to developing PPI consultation schemes. These schemes detail how the ALB will consult and involve service users in the planning and delivery of services. The statutory duty of involvement and consultation does not apply to, NISCC, NIPEC, BSO and NIFRS. However, the Department would encourage all ALBs to put appropriate and proportionate measures in place to ensure that their service delivery arrangements are informed by views of those who use their services.

Under Section 75 (NI Act 1998) all ALBs have existing obligations and commitments to consult with the public, service users and carers in the planning, delivery and monitoring of services. Under Section 49a of the Disability Discrimination Act NI (1995) ALBs have a duty to promote the involvement of disabled people in public life.

Red Flag	Good Practice
1. The development of the Business Plan has only involved the Board and a limited number of ALB staff. 2. The ALB has poor relationships with external stakeholders, with examples including clients, client organisations etc. 3. Feedback from clients is negative e.g. complaints, surveys and findings from regulatory and review reports. 4. The ALB has failed to manage adverse negative publicity effectively in relation to the services it provides in the last 12 months.	1. Where relevant, the Board has an approved PPI consultation scheme which formally outlines and embeds their commitment to the involvement of service users and their carers in the planning and delivery of services. 2. A variety of methods are used by the ALB to enable the Board and senior management to listen to the views of service users, commissioners and the wider public, including 'hard to reach' groups like non-English speakers and service users with a learning disability. The Board has ensured that various processes are in place to effectively and efficiently respond to these views and can provide evidence of these processes operating in practice. 3. The Board can evidence how key external stakeholders (e.g. service users, commissioners and MLAs) have been engaged in the development of their business plans for the ALB and provide examples of where their views have been included and not included in the Business Plan. 4. The Board has ensured that various communication methods have been deployed to ensure that key external stakeholders understand the key messages within the Business Plan.

5. The Board has not overseen a system for receiving, acting on and reporting outcomes of complaints.	5. The Board promotes the reporting and management of, and implementing the learning from, adverse incidents/near misses occurring within the context of the services that they provide 6. The ALB has constructive and effective relationships with its key stakeholders.
Examples of evidence that could be submitted to support the Board's RAG rating.	• PPI Consultation Scheme • Complaints • Customer Survey • Regulatory and Review reports

4. Board engagement and involvement

4.2 Internal stakeholders

Red Flag	Good Practice
1. The ALBs latest staff survey results are poor. 2. There are unresolved staff issues that are significant (e.g. the Board or individual Board members have received 'votes of no confidence', the ALB does not have productive relationships with staff side/trade unions etc.). 3. There are significant unresolved quality issues. 4. There is a high turn over of staff. 5. Best practise is not shared within the ALB.	1. A variety of methods are used by the ALB to enable the Board and senior management to listen to the views of staff, including 'hard to reach' groups like night staff and weekend workers. The Board has ensured that various processes are in place to effectively and efficiently respond to these views and can provide evidence of these processes operating in practice. 2. The Board can evidence how staff have been engaged in the development of their Corporate & Business Plans and provide examples of where their views have been included and not included. 3. The Board ensures that staff understand the ALB's key priorities and how they contribute as individual staff members to delivering these priorities. 4. The ALB uses various ways to celebrate services that have an excellent reputation and acknowledge staff that have made an outstanding contribution to service delivery and the running of the ALB. 5. The Board has communicated a clear set of values/behaviours and how staff that do not behave consistent with these valves will be managed. Examples can be provided of how management have responded to staff that have not behaved consistent with the ALB's stated values/behaviours. 6. There are processes in place to ensure that staff are informed about major risks that might impact on customers, staff and the ALB's reputation and understand their personal responsibilities in relation to minimising and managing these key risks.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Staff Survey • Grievance and disciplinary procedures • Whistle blowing procedures • Code of conduct for staff • Internal engagement or communications strategy/ plan.

4. Board engagement and involvement

4.3 Board profile and visibility

Red Flag	Good Practice
1. With the exception of Board meetings held in public, there are no formal processes in place to raise the profile and visibility of the Board. 2. Attendance by Board members is poor at events/meetings that enable the Board to engage with staff (e.g. quality/leadership walks; staff awards, drop in sessions).	1. There is a structured programme of events/meetings that enable NEDs to engage with staff (e.g. quality/leadership walks; staff awards, drop in sessions) that is well attended by Board members and has led to improvements being made. 2. There is a structured programme of meetings and events that increase the profile of key Board members, in particular, the Chair and the CE, amongst external stakeholders. 3. Board members attend and/or present at high profile events. 4. NEDs routinely meet stakeholders and service users. 5. The Board ensures that its decision-making is transparent. There are processes in place that enable stakeholders to easily find out how and why key decisions have been made by the Board without reverting to freedom of information requests. 6. As a result of the Board member appraisal and personal development process, Board members can evidence improvements that they have made in the quality of their contributions at Board-level.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Board programme of events/ quality walkabouts with evidence of improvements made • Active participation at high-profile events • Evidence that Board minutes are publicly available and summary reports are provided from private Board meetings

5. Board Governance Self- Assessment Submission

Name of ALB **Southern Health and Social Care Trust**

Approved by Eileen Mullan (ALB Chair)

1. Board composition and commitment ALB Name *Southern HSC Trust* Date *September 2023*

1.1 Board positions and size

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas where training or guidance is required and/or Areas were additional assurance is required
GP1	*The size of the Board (including voting and non-voting members of the Board) and Board committees is appropriate for the requirements of the business. All voting positions are substantively filled.* Size of the Board is in accordance with the Southern Health and Social Services (Establishment) Order (N Ireland) 2006, Health and Social Services Trusts (Membership and Procedure) Regulations (NI) 1994. 10/11 Senior Executive posts now filled permanently. Interim Director of Children and Young People's Services/ Executive Director of Social Work in place from September 2021 **<u>Evidence</u>** Board Minutes Job Descriptions Biographical information on each Board member	DoH led Non Executive Director recruitment process, including SHSCT vacancies, underway. Outcome awaited – Autumn 2023 Plans in place to permanently recruit to Executive Director of Social Work/Director of Children & Young People's Services – September 2023.	2 out of 7 Non Executive Director positions remain vacant. 2 Non Executive Directors will complete their term of office on 14.2.2024 and 3 will complete their term of office on 31.12.2024	

GP2	*The Board ensures that it is provided with appropriate advice, guidance and support to enable it to effectively discharge its responsibilities.* **Evidence** Standing Orders and Standing Financial Instructions Management Statement/ Financial Memorandum Board Development Programme Board Assurance Manager Attendance at subject specific events	None required	Not applicable	None identified
GP3	*It is clear who on the Board is entitled to vote.* **Evidence** Addressed in Standing Orders HSS Trusts (Membership Procedures) Regulations NI 1996	None required	Not applicable	None identified
GP4	*The composition of the Board and Board committees accords with the requirements of the relevant Establishment Order or other legislation, and/or the ALB's Standing Orders.* **Evidence** Standing Orders	None required	Not applicable	None identified

GP5	*Where necessary, the appointment term of NEDs is staggered so they are not all due for re-appointment or to leave the Board within a short space of time*. **Evidence** NEDs appointments staggered – letters of appointment	None required	Not applicable	None identified

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	None identified	The Chair and Chief Executive positions are filled.
RF2	None identified	More than 50% of the Board has remained constant in the previous two years.
RF3	None identified	All Trust Board meetings are quorate. Non attendance is by agreement with the Chair and a nominated Deputy attends in a Director's absence. Attendance at Board meetings is included in the Trust's Annual Governance Statement.

1. Board composition and commitment ALB Name *Southern HSC Trust* Date *September 2023*

1.2 Balance and calibre of Board members

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas where training or guidance is required and/or Areas were additional assurance is required
GP1	*The Board can clearly explain why the current balance of skills, experience and knowledge amongst Board members is appropriate to effectively govern the ALB over the next 3-5 years. In particular, this includes consideration of the value that each NED will provide in helping the Board to effectively oversee the implementation of the ALB's business plan.* Trust Board considers the current balance of skills to be appropriate Allocation of NEDs to Sub Committees of the Board based on their skills, experience and knowledge **<u>Evidence</u>** Biographical information Committee membership Appraisals process Skills Matrix completed by Non Executive Directors in September 2022	None required	Not applicable	None identified

GP2	*The Board has an appropriate blend of NEDs e.g. from the public, private and voluntary sectors.* **Evidence** Biographical information Declaration/Register of Interests	Note: Skills Matrix completed in September 2022 in advance of recruitment of 2 vacant NED positions	Not applicable	None identified
GP3	*The Board has had due regard under Section 75 of the Northern Ireland Act 1998 to the need to promote equality of opportunity: between persons of different religious belief, political opinion, racial group, age, marital status or sexual orientation; between men and women generally; between persons with a disability and persons without; and between persons with dependants and persons without.* **Evidence** Equality Scheme approved by Trust Board Board Minutes S75 Annual Progress Report to Trust Board	None required	Not applicable	None identified
GP4	*There is at least one NED with a background specific to the business of the ALB.* Yes **Evidence** Biographical information	None required	Not applicable	None identified

GP5	*Where appropriate, the Board includes people with relevant technical and professional expertise.* **Evidence** Biographical information Directors' Job Descriptions	None required	Not applicable	None identified
GP6	*There is an appropriate balance between Board members (both Executive and NEDs) that are new to the Board (i.e. within their first 18 months) and those that have served on the Board for longer.* The majority of Board members (both Executive and NEDs) have served on the Board for longer than 18 months **Evidence** Board membership	None required	Not applicable	None identified
GP7	*The majority of the Board are experienced Board members* Yes – the majority of the Board are experienced Board members. **Evidence** Biographical information	None required	Not applicable	None identified
GP8	*Where appropriate, the Chair of the Board has a demonstrable and recent track record of successfully leading a large and complex organisation, preferably in a regulated environment.* Yes	None required	Not applicable	None identified

	Evidence Biographical information			
GP9	*The Chair of the Board has previous non-executive experience.* Yes – the Chair has previous Non Executive experience **Evidence** Biographical information	None required	Not applicable	None identified
GP10	*At least one member of the Audit Committee has recent and relevant financial experience.* Yes – the Chair of the Audit Committee has recent and relevant financial experience **Evidence** Biographical information	None required	Not applicable	None identified

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	None identified	NED Chair of Audit Committee has a recent and relevant financial background
RF2	None identified	NEDs with current or recent (within the previous 2 years) experience in the private/commercial sector
RF3	None identified	Majority of Board members are not in their first Board position
RF4	None identified	Majority of members have served on the Board > 18 months.
RF5	None identified	Balance of Directors/Non Executive Directors is correct
RF6	None identified	Non Executive Director membership on Committees strengthened

1. Board composition and commitment ALB Name *Southern HSC Trust* Date *September 2023*

1.3 Role of the Board

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas where training or guidance is required and/or Areas were additional assurance is required
GP1	*The role and responsibilities of the Board have been clearly defined and communicated to all members.* **Evidence** Standing Orders Induction Programme Job Descriptions Code of Conduct and Code of Accountability Management Statement/Financial Memorandum	None required	Not applicable	None identified
GP2	*Board members are clear about the Minister's policies and expectations for their ALBs and have a clearly defined set of objectives, strategy and remit.* Chair ensures Board members are clear on Ministerial priorities and direction **Evidence** Management Statement/Financial Memorandum Code of Accountability	None required	Not applicable	None identified

GP3	*There is a clear understanding of the roles of Executive officers and Non Executive Board members.* **Evidence** Job Descriptions Code of Conduct and Code of Accountability Management Statement/Financial Memorandum Standing Orders	None required	Not applicable	None identified
GP4	*The Board takes collective responsibility for the performance of the ALB.* **Evidence** Performance Framework Performance Committee reporting to Trust Board Code of Conduct and Code of Accountability Management Statement/Financial Memorandum Standing Orders Finance Report to Trust Board Board Assurance Framework Approval of Annual Report and Accounts	None required	Not applicable	None identified

GP5	*NEDs are independent of management.* Yes – NEDs are independent of management **Evidence** Job Descriptions Articulated in Codes of Conduct and Accountability Board Minutes to demonstrate challenge function	None required	Not applicable	None identified
GP6	*The Chair has a positive relationship with the Minister and sponsor Department.* Yes **Evidence** Minutes of Mid and Year End Accountability Review meetings	None required	Not applicable	None identified
GP7	*The Board holds management to account for its performance through purposeful, challenge and scrutiny.* **Evidence** Challenge and scrutiny function evident from Board Minutes Performance Committee Chair report to Trust Board Monthly finance reports to Trust Board	None required	Not applicable	None identified

	Scrutiny of Governance Statement, Annual Report and Accounts Trust Corporate Plan – annual progress updates to Trust Board Formal Scheme of Delegation			
GP8	*The Board operates as an effective team.* **Evidence** Consensus approach to decision-making evidenced in Board minutes IA Report on Board Effectiveness – satisfactory level of assurance	None identified	Not applicable	None identified
GP9	*The Board shares corporate responsibility for all decisions taken and makes decisions based on clear evidence.* **Evidence** Board Minutes Robust system of identifying matters arising and follow up (action log)	None identified	Not applicable	None identified
GP10	*Board members respect confidentiality and sensitive information.* **Evidence** Trust Board confidential section for sensitive information	None identified	Not applicable	None identified

	Board Behaviours Information Governance training			
GP11	*The Board governs, Executives manage.* Yes – The Board confirms that it governs the organisation and holds the Executive Team to account through purposeful challenge and scrutiny. **Evidence** Board Minutes and Action log	None identified	Not applicable	None identified
GP12	*Individual Board members contribute fully to Board deliberations and exercise a healthy challenge function.* Board members contribute to Board discussions and challenge the Executive Team. **Evidence** Board Minutes	None identified	Not applicable	None identified
GP13	*The Chair is a useful source of advice and guidance for Board members on any aspect of the Board.* Yes – Chair well informed and provides updates on actions/activities/key developments at Board meetings **Evidence** Board Minutes	None identified	Not applicable	None identified

	Individual meetings with NEDs 1:1 appraisals Chair's Induction meeting with new members			
GP14	*The Chair leads meetings well, with a clear focus on the issues facing the ALB, and allows full and open discussions before major decisions are taken.* The Chair allows open discussion before decisions are made. Board Minutes attest to this. **Evidence** Board Minutes IA Report on Board Effectiveness	None identified	Not applicable	None identified
GP15	*The Board considers the concerns and needs of all stakeholders and actively manages its relationships with them.* **Evidence** Trust Board meetings held in public Specific meetings with interested groups PPI Consultation Scheme Consultations on Trust Strategies engage stakeholders during development	None identified	Not applicable	None identified

GP16	*The Board is aware of and annually approves a scheme of delegation to its committees*. **Evidence** Scheme of Delegation from Board to Committees approved by Board annually	None identified	Not applicable	None identified
GP17	*The Board is provided with timely and robust post-evaluation reviews on all major projects and programmes*. Board delegated responsibility to the Audit Committee **Evidence** Annual summary report of Post Project Evaluations (PPEs) completed on Capital and Revenue proposals > £300,000 to Audit Committee Audit Committee agenda and minutes	None identified	Not applicable	None identified

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	None identified	The Chair does not look constantly to the Chief Executive to speak or give a lead on issues – evidence via Trust Board Minutes
RF2	None identified	The Board does not tend to focus on details but on strategy, culture and accountability – evidence via Trust Board Minutes
RF3	None identified	The Board does not become involved in operational areas – evidence via Trust Board Agendas and Minutes
RF4	None identified	The Board is able to take a decision without the Chief Executive's recommendation – evidence via Trust Board Minutes

RF5	None identified	The Board does not allow the Chief Executive to dictate the Agenda – evidence via Trust Board Minutes and Agenda
RF6	None identified	Reguarly, one individual Board member does not dominate the debates or has an excessive influence on Board decision making – evidence via Trust Board Minutes

1. Board composition and commitment **ALB Name** ***Southern HSC Trust*** **Date** ***September 2023***

1.4 Committees of the Board

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas where training or guidance is required and/or Areas were additional assurance is required
GP1	*Clear terms of reference are drawn up for each Committee including whether it has powers to make decisions or only make recommendations to the Board.* **Evidence** Clear Terms of Reference for each Committee in place and approved by Trust Board on an annual basis Board Minutes Scheme of Delegation	Note: Under new corporate and clinical and social care governance structure, Committee Terms of reference have been reviewed and revised.	Not applicable	None identified
GP2	*Certain tasks or functions are delegated to the Committee but the Board as a whole is aware that it carries the ultimate responsibility for the actions of its Committees.* **Evidence** The Board recognises that it carries responsibility for the actions of its Committees. Reflected in: – **Evidence** Scheme of Delegation Terms of Reference	None required	Not applicable	None identified

GP3	*Schemes of delegation from the Board to the Committees are in place.* **Evidence** Scheme of Delegation	None required	Not applicable	None identified
GP4	*There are clear lines of reporting and accountability in respect of each Committee back to the Board.* **Evidence** Scheme of Delegation Terms of Reference Committee Minutes to Trust Board Committee Chair Reports to Trust Board Committee Annual Reports to Trust Board Board Minutes Governance High Level Organisational Chart	None required	Not applicable	None identified
GP5	*The Board agrees, with the Committees, what assurances it requires and when, to feed its annual business cycle.* **Evidence** Board Assurance Framework Terms of Reference approved by Trust Board on an annual basis	None required	Not applicable	None identified

	Workplan/Schedule of Reporting in place for each Committee and agreed by Trust Board on an annual basis Trust Board Annual Cycle			
GP6	*The Board receives regular reports from the Committees which summarises the key issues as well as decisions or recommendations made.* **<u>Evidence</u>** Committee Chair Reports to Trust Board Committee Minutes Board Minutes	None required	Not applicable	None identified
GP7	*The Board undertakes a formal and rigorous annual evaluation of the performance of its Committees.* **<u>Evidence</u>** Annual Evaluation undertaken and reported via Committees' Annual Reports – Audit, Governance, Performance, E&G, Patient & Client Experience Audit Committee self-assessment in line with NAO guidance	None required	Not applicable	None identified

GP8	*It is clearly documented who is responsible for reporting back to the Board.* **Evidence** Responsibility of Committee Chairs as per Terms of Reference	None required	Not applicable	None identified

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	None identified	Minutes of Committee meetings are presented by relevant Chair as well as Committee Chair reports
RF2	None identified	Committee members do receive performance management appraisals in relation to their Committee role (appraisal template). NED appraisals include discussion on the Sub Committees they Chair
RF3	None identified	Terms of Reference in place for all Committees
RF4	None identified	Non Executive Directors fully aware of the differing roles between the Board and Committees. NED Induction programme.
RF5	None identified	Draft agendas for Committee meetings are drafted by the Board Assurance Manager/Committee Secretary and discussed by the Senior Leadership Team

1. Board composition and commitment ALB Name *Southern HSC Trust* Date *September 2023*

1.5 Board member commitment

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas where training or guidance is required and/or Areas were additional assurance is required
GP1	*Board members have a good attendance record at all formal Board and Committee meetings and at Board events.* Good attendance rates of Board members at Trust Board and Committee meetings during 2022/23. **<u>Evidence</u>** Board attendance as evidenced in Board and Committee attendance records. These are presented to the Board for review on an annual basis as part of the Annual Reports from Committees. Board attendance evidenced in Governance Statement Board Development Programme attendance record Board and Committee Minutes Annual Performance Appraisal of NEDs identifies high attendance at events and meetings	None required	Not applicable	None identified

GP2	*The Board has discussed the time commitment required for Board (including Committee) business and Board development, and Board members have committed to set aside this time.* **Evidence** Board Behaviours Good Practice Principles for Board and Committees Reinforced by Chair at Board meetings – Board Minutes Induction Programme	None required	Not applicable	None identified
GP3	*Board members have received a copy of the Department's Code of Conduct and Code of Accountability for Board Members of Health and Social Care Bodies or the Northern Ireland Fire and Rescue Service. Compliance with the code is routinely monitored by the Chair.* **Evidence** All Board members have received a copy of the Codes of Conduct and Accountability Compliance with the Codes included as part of NED annual appraisal – NED Annual Appraisal form	None required	Not applicable	None identified

GP4	*Board meetings and Committee meetings are scheduled at least 6 months in advance.* **Evidence** Schedule of Board and Sub Committee meetings issued Board Minutes	None required	Not applicable	None identified

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	None identified	No record of Board or Committee meetings not being quorate.
RF2	None identified	All non-attendance at Board meetings is reviewed by the Chair and all non-attendance at Committee meetings is reviewed by the respective Committee Chair.
RF3	None identified	Non attendance is by agreement with the Chair and a nominated relevant Deputy attends in a Director's absence.
RF4	None identified	Board members behave consistently as per Code of Conduct and Code of Accountability
RF5	None identified	Attendance at Board and Sub Committees is reviewed annually and included in the Committee's Annual Report to Trust Board.

2. Board evaluation, development and learning ALB Name *Southern HSC Trust* Date *September 2023*

2.1 Effective Board level evaluation

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas where training or guidance is required and/or Areas were additional assurance is required
GP1	*A formal Board Governance Self-Assessment has been conducted within the previous 12 months.* **Evidence** Board Governance Self-Assessment completed at Workshop on 25th August 2022 and formally approved by Trust Board at meeting on 29th September 2022 (Note – no requirement to submit to Department of Health)	None required	Not applicable	None identified
GP2	*The Board can clearly identify a number of changes/ improvements in Board and Committee effectiveness as a result of the formal self assessments that have been undertaken.* **Evidence** Board Self-Assessment Action Plan in place. Updated and reviewed each year. Action points from 2022/22 self-assessment have now been progressed as follows:- Senior Management structure implemented in 2022-23 Department led recruitment exercise for SHSCT NEDs	None required	Not applicable	None identified

	New approach for corporate and clinical and social care governance agreed and currently being implemented			
GP3	*The Board has had an independent evaluation of its effectiveness and the effectiveness of its committees within the last 3 years by a 3rd party that has a good track record in undertaking Board effectiveness evaluations.* **Evidence** Independent input required at least once every 3 years and this was included in the Internal Audit report on Board Effectiveness 2021/22	None required	Not applicable	None identified
GP4	*In undertaking its self assessment, the Board has used an approach that includes various evaluation methods. In particular, the Board has considered the perspective of a representative sample of staff and key external stakeholders (e.g. commissioners, service users and clients) on whether or not they perceive the Board to be effective.* **Evidence** Top down approach adopted to encourage engagement and attendance of staff at Trust Board meetings to share examples that epitomise what Trust business is about Attendance of staff and Assistant Directors at Trust	The Board continues to utilise the information gathered from these sources as a potential indicator of board effectiveness.		

	Board meetings and their perspective sought at end of meeting Suggestions for improvements taken on board to enhance Board effectiveness. One example is that access to papers by public members and staff has been made available on Sharepoint prior to each meeting. Public attendance at Trust Board meetings			
GP5	*The focus of the self assessment included traditional 'hard' (e.g. Board information, governance structure) and 'soft' dimensions of effectiveness.* **Evidence** Board Development Programme in place which includes time out for the Board to reflect on its effectiveness and focus for the future			

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	None identified	
RF2	None identified	
RF3	None identified	
RF4	None identified	

2. Board evaluation, development and learning ALB Name *Southern HSC Trust* Date *September 2023*

2.2 Whole Board development programme

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas where training or guidance is required and/or Areas were additional assurance is required
GP1	*The Board has a programme of development in place. The programme seeks to directly address the findings of the Board's annual self assessment and contains the following elements: understanding the relationship between the Minister, the Department and their organisation, e.g. as documented in the Management Statement; development specific to the business of their organisation; and reflecting on the effectiveness of the Board and its supporting governance arrangements.* **<u>Evidence</u>** Self-assessment and findings to Board Workshop annually Board Development Programme – ongoing series of workshops on strategy, accountability and culture. Examples include: • Financial Planning 2023-24 • Whistleblowing • Risk Appetite Board members Induction process	None required	Not applicable	None identified

GP2	*Understanding the relationship between the Minister, Department and the ALB - Board members have an appreciation of the role of the Board and NEDs, and of the Department's expectations in relation to those roles and responsibilities.* **Evidence** Management Statement/Financial Memorandum Draft DoH Partnership Agreement template and Proportionate Autonomy for ALBs guidance Codes of Conduct and Accountability	None required	Not applicable	None identified
GP3	*Development specific to the ALB's governance arrangements – the Board is or has been engaged in the development of action plans to address governance issues arising from previous self-assessments/independent evaluations, Internal Audit reports, serious adverse incident reports and other significant control issues.* **Evidence** Governance arrangements – monitored by Governance Committee.	None required	Not applicable	None identified

GP4	*Reflecting on the effectiveness of the Board and its supporting governance arrangements -The development programme includes time for the Board as a whole to reflect upon, and where necessary improve.* **Evidence** Board Development Programme allows protected time for reflection and improvement. Board Development Day took place on 25th August 2022 to critically evaluate the current corporate and clinical and social care governance structure and process and explore a proposed new approach	None required	Not applicable	None identified
GP5	*Time is 'protected' for undertaking this programme and it is well attended.* **Evidence** Board Development Day is scheduled one year in advance and is well attended. Attendance record	None required	Not applicable	None identified
GP6	*The Board has considered, at a high-level, the potential development needs of the Board to meet future challenges*. Board Workshops provide time out for members to think about the Board as a whole and its		Not applicable	None identified

	training and developmental needs. Involvement of the Board in planning/strategy was an area of development identified and work in this area continued during 2021/22. **Evidence** Workshop agendas focusing on vision, strategy and culture (see GP1 above)			

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	None identified	Board Development Programme in place
RF2	None identified	None required

2. Board evaluation, development and learning ALB Name *Southern HSC Trust* Date *September 2023*

2.3 Board induction, succession and contingency planning

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas where training or guidance is required and/or Areas were additional assurance is required
GP1	*All members of the Board, both Executive and Non-Executive, are appropriately inducted into their role as a Board member. Induction is tailored to the individual Director and includes access to external training courses where appropriate. As a minimum, it includes an introduction to the role of the Board, the role expectations of NEDs and Executive Directors, the statutory duties of Board members and the business of the ALB.* **Evidence** Induction process On Board programme	None required	Not applicable	None identified
GP2	*Induction for Board members is conducted on a timely basis.* **Evidence** Induction process	None required	Not applicable	None identified
GP3	*Where Board members are new to the organisation, they have received a comprehensive corporate induction which includes an overview of the services provided by the ALB, the organisation's structure, ALB values and meetings with key leaders.* **Evidence** Induction process	None required	Not applicable	None identified

GP4	*Deputising arrangements for the Chair and CE have been formally documented.* **Evidence** Appropriate deputising arrangements in place for when the Chair and Chief Executive are not available Appointment of 2 Deputy Directors	None required	Not applicable	None identified
GP5	*The Board has considered the skills it requires to govern the organisation effectively in the future and the implications of key Board-level leaders leaving the organisation. Accordingly, there are demonstrable succession plans in place for all key Board positions.* **Evidence** Senior Management Team Development Programme Attendance of Assistant Directors at Board Committee meetings to present and also at Board meetings to deputise or attend with Directorate staff colleagues	Regional Aspiring Directors Succession Planning programme seeking nominees for 2022/23 programme and these are being identified within the Trust to complete future succession planning Further work required to develop succession plans for Board level positions into the future	Not applicable	None identified

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	None identified	New Board members attend the On Board training within 3 months of appointment
RF2	None identified	Documented arrangements in place for Chairing Board and Committee meetings if the Chair is unavailable.

RF3	None identified	Documented arrangements in place in respect of how the organisation is to be represented at a senior level at Board meetings if the Chief Executive is unavailable.
RF4	None identified	NED appointments are staggered.

2. Board evaluation, development and learning ALB Name *Southern HSC Trust* Date *September 2023*

2.4 Board member appraisal and personal development

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas where training or guidance is required and/or Areas were additional assurance is required
GP1	*The effectiveness of each Non-Executive Board member's contribution to the Board and corporate governance is formally evaluated on an annual basis by the Chair* **Evidence** Annual Performance Appraisals of NEDs completed annually by the Chair	None required	Not applicable	None identified
GP2	*The effectiveness of each Executive Board member's contribution to the Board and corporate governance is formally evaluated on an annual basis in accordance with the appraisal process prescribed by their organisation.* **Evidence** Annual Performance Appraisals of Directors completed annually by the Chief Executive. New appraisal documentation includes Board member role	None required	Not applicable	None identified

GP3	*There is a comprehensive appraisal process in place to evaluate the effectiveness of the Chair of the Board that is led by the relevant Deputy Secretary (and countersigned by the Permanent Secretary).* **Evidence** Appraisal forms	None required	Department is responsible for co-ordinating the appraisal process.	None identified
GP4	*Each Board member (including each Executive Director) has objectives specific to their Board role that are reviewed on an annual basis.* **Evidence** Annual Appraisal form for NEDs Directors' Performance Appraisals which address personal development needs Objectives set for Directors by Chief Executive. In the case of the Chief Executive, this is undertaken by the Chair	None required	Not applicable	None identified
GP5	*Each Board member has a Personal Development Plan that is directly relevant to the successful delivery of their Board role.* **Evidence** Assessment forms have an option for members to detail specific issues for the coming year	None required	Not applicable	None identified

GP6	*As a result of the Board member appraisal and personal development process, Board members can evidence improvements that they have made in the quality of their contributions at Board-level.* **Evidence** Board Minutes demonstrate challenge function Development of reporting to Trust Board	None required	Not applicable	None identified
GP7	*Where appropriate, Board members comply with the requirements of their respective professional bodies in relation to continuing professional development and/or certification*. **Evidence** All Board members subscribe to the Code of Conduct and, where appropriate, comply with the requirements of their respective professional bodies.	None required	Not applicable	None identified

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	None identified	Robust performance appraisal process in place.
RF2	None identified	Induction programme. Formal training and development and/or professional development is encouraged and in operation.
RF3	None identified	Time is set aside for appraisals and these are undertaken in a timely fashion for NEDs. Process to identify training needs of NEDs commences well in advance of appraisal meeting.
RF4	None identified	The Chair fully considers the differing roles of Board and Committee members.

3. Board insight and foresight ALB Name *Southern HSC Trust* Date *September 2023*

3.1 Board performance reporting

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas where training or guidance is required and/or Areas were additional assurance is required
GP1	*The Board has debated and agreed a set of quality and financial performance indicators that are relevant to the Board given the context within which it is operating and what it is trying to achieve. Indicators should relate to priorities, objectives, targets and requirements set by the Dept.* **<u>Evidence</u>** Monthly Board Performance Reports – Finance and Corporate CPD Performance Scorecard Board Minutes Performance Committee with delegated responsibility for performance management which meets quarterly - Performance Committee Terms of Reference	None required	Not applicable	None identified
GP2	*The Board receives a performance report which is readily understandable for all members.* **<u>Evidence</u>** Monthly Corporate Performance Scorecard	None required	Not applicable	None identified

GP3	*The Board receives a brief verbal update on key issues arising from each Committee meeting from the relevant Chair. This is supported by a written summary of key items discussed by the Committee and decisions made.* **Evidence** Committee Chair Report to Trust Board Board Agenda and Minutes highlighting Committee discussions	None required	Not applicable	None identified
GP4	*The Board regularly discusses the key risks facing the ALB and the plans in place to manage or mitigate them.* **Evidence** Board Reports Board Minutes Board Assurance Framework and Corporate Risk Register	None required	Not applicable	None identified
GP5	*An action log is taken at Board meetings. Accountable individuals and challenging/demanding timelines are assigned. Progress against actions is actively monitored. Slips in timelines are clearly identifiable through the action log and individuals are held to account*. **Evidence**	None required	Not applicable	None identified

	Template in place for Board and Committee meetings where individuals and timescales are identified and progress actively monitored at subsequent meetings.			

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	None identified	Performance reports report significant unplanned variances and reasons for same
RF2	None identified	No performance failures were brought to the Board's attention by an external party
RF3	None identified	Finance and Patient, Safety and Quality reports considered together
RF4	None identified	Action log in place
RF5	None identified	Key risks reported/escalated to the Board as and when required

3. Board insight and foresight ALB Name *Southern HSC Trust* Date *September 2023*

3.2 Efficiency and Productivity

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas where training or guidance is required and/or Areas were additional assurance is required
GP1	*The Board is assured that there is a robust process for prospectively assessing the risk(s) to quality of services and the potential knock-on impact on the wider health and social care community of implementing efficiency and productivity plans.* **Evidence** Performance Report Minutes of Trust Board meetings and Directors' Workshop Notes on specific risks/projects Board Assurance Framework	None required	Not applicable	None identified
GP2	*The Board can provide examples of efficiency and productivity plans that have been rejected or significantly modified due to their potential impact on quality of service.* **Evidence** Financial Plan	None required	Not applicable	None identified
GP3	*The Board receives information on all efficiency and productivity plans on a regular basis. Schemes are allocated to Directors and are RAG rated to highlight where performance is not in line with plan. The risk(s) to non-*	None required	Not applicable	None identified

	achievement is clearly stated and contingency measures are articulated. **Evidence** Financial Plan includes efficiency and productivity plans Issues reported to Trust Board on an exception basis			
GP4	*There is a process in place to monitor the ongoing risks to service delivery for each plan, including a programme of formal post implementation reviews.* **Evidence** Accountability Review meetings PPEs to Audit Committee Board Assurance Framework	None required	Not applicable	None identified

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	None identified	The Board receives regular performance information relating to progress against efficiency and productivity plans
RF2	None identified	Process in place to prospectively assess the risk(s) to quality of services presented by efficiency and productivity plans.
RF3	None identified	Financial Planning process considers where potential savings can be made with least impact on quality of care
RF4	None identified	Board Assurance Framework in place

3. Board insight and foresight ALB Name *Southern HSC Trust* Date *September 2023*

3.3 Environmental and strategic focus

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas where training or guidance is required and/or Areas were additional assurance is required
GP1	*The Chief Executive presents a report to every Board meeting detailing important changes or issues in the external environment (e.g. policy changes, quality and financial risks). The impact on strategic direction is debated and, where relevant, updates are made to the ALB's risk registers and Board Assurance Framework (BAF).* **Evidence** Chief Executive's report is a standing item on the Trust Board agenda Board Minutes Directors' Workshops Board Assurance Framework	None required	Not applicable	None identified
GP2	*The Board has reviewed lessons learned from SAIs, reports on discharge of statutory responsibilities, negative reports from independent regulators etc and has considered the impact upon them. Actions arising from this exercise are captured and progress is followed up.* **Evidence** Board agendas and minutes	None required	Not applicable	None identified

	Directors' Workshop agendas and notes Where further action/assurance is required, Trust Board remit to Governance Committee to monitor progress			
GP3	*The Board has conducted or updated an analysis of the ALB's performance within the last year to inform the development of the Business Plan.* **Evidence** Annual progress against the Corporate Plan presented to Trust Board	None required	Not applicable	None identified
GP4	*The Board has agreed a set of corporate objectives and associated milestones that enable the Board to monitor progress against implementing its vision and strategy for the ALB. Performance against these corporate objectives and milestones are reported to the board on a quarterly basis.* **Evidence** Corporate Objectives defined in Corporate Plan 2022/23. Compliance against the Corporate Plan is monitored throughout the year and reported to Trust Board.	None required	Not applicable	None identified

GP5	*The Board's annual programme of work sets aside time for the Board to consider environmental and strategic risks to the ALB. Strategic risks to the ALB are actively monitored through the Board Assurance Framework (BAF)*. Annual Board Cycle of Work Environmental and Strategic risks actively monitored through the Board Assurance Framework Directors Workshops for strategic planning	None required	Not applicable	None identified

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	None identified	The Board has a clear understanding of Executive/Departmental priorities and its statutory responsibilities, business plans etc.
RF2	None identified	The Board has a programme of work in place. Workshops also regularly consider environmental and strategic risks.
RF3	None identified	The Board regularly reviews progress towards delivering its strategies.

3. Board insight and foresight ALB Name *Southern HSC Trust* Date September 2023

3.4 Quality of Board papers and timeliness of information

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas where training or guidance is required and/or Areas were additional assurance is required
GP1	*The Board can demonstrate that it has actively considered the timing of the Board and Committee meetings and presentation of Board and Committee papers in relation to month and year end procedures and key dates to ensure that information presented is as up-to-date as possible and that the Board is reviewing information and making decisions at the right time.* **Evidence** Schedule of Board and Committee meetings take account of month and year end procedures and key dates Annual Business Cycle Board meetings take place on last Thursday of the month to allow timely presentation of information	None required	Not applicable	None identified
GP2	*A timetable for sending out papers to members is in place and adhered to.* **Evidence** Board meeting timetable as per Standing Orders	None required	Not applicable	None identified

	Internal Timetable in place re issue of Sub Committee papers Paperless approach adopted via DecisionTime			
GP3	*Each paper clearly states what the Board is being asked to do (e.g. noting, approving, decision, and discussion).* **Evidence** As outlined in Board Cover Sheet	None required	Not applicable	None identified
GP4	*Board members have access to reports to demonstrate performance against key objectives and there is a defined procedure for bringing significant issues to the Board's attention outside of formal meetings.* **Evidence** Performance Report Monthly Finance Report Progress update against the Corporate Plan objectives and outcomes presented to Board annually Process in place for access to reports to demonstrate performance outside of formal meetings.	None required	Not applicable	None identified

GP5	*Board papers outline the decisions or proposals that Executive Directors have made or propose. This is supported; where appropriate, by: an appraisal of the relevant alternative options; the rationale for choosing the preferred option; and a clear outline of the process undertaken to arrive at the preferred option, including the degree of scrutiny that the paper has been through.* **Evidence** Each Board paper has an accompanying Board Cover Sheet ensuring that the paper is aligned to specific corporate objectives. Key areas /decisions required are drawn to members' attention as well as the areas of concern/risk/challenge.	None required	Not applicable	None identified
GP6	*The Board is routinely provided with data quality updates. These updates include external assurance reports that data quality is being upheld in practice and are underpinned by a programme of clinical and/or internal audit to test the controls that are in place.* **Evidence** Performance Reports Mortality Reports to Governance Committee Internal audit reports to Audit Committee External Assurance Performance Reports to Performance Committee	None required	Not applicable	None identified

GP7	*The Board can provide examples of where it has explored the underlying data quality of performance measures. This ensures that the data used to rate performance is of sufficient quality.* **Evidence** Annual internal audit of presentation of performance management to the Board and underlying data quality CHKS provides peer comparison which supports wider view of performance data Membership of NHS Benchmarking in place to enable to support rolling programme of review of Trust services. Implementation of Quality Improvement and Patient Safety Strategy to bring greater connectivity to a range of indicators including quality and safety and patient experience measures	None required	Not applicable	None identified
GP8	*The Board has defined the information it requires to enable effective oversight and control of the organisation, and the standards to which that information should be collected and quality assured.* **Evidence** Trust Board Cycle of Reporting	Evolving process	Not applicable	None identified

	Board Assurance Framework			
GP9	*Board members can demonstrate that they understand the information presented to them, including how that information was collected and quality assured, and any limitations that this may impose.* **Evidence** Understanding of information presented demonstrated through challenge function of members via Board minutes. Assurance to Board on performance of 'improvement trajectories' included in performance reporting on exception basis. Clinical and Social Care Governance Reporting to Governance Committee	None required	Not applicable	None identified
G10	*Any documentation being presented complies with Departmental guidance, where appropriate e.g. business cases, implementation plans.* Documentation presented to the Board complies with Departmental guidance, circulars etc.	None required	Not applicable	None identified

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	None identified	Board papers issued via DecisionTime five working days in advance of the meeting
RF2	None identified	Board discussions focus on understanding of issues and providing clarity, where required, to ensure that decision making is well informed
RF3	None identified	Data quality is checked and validated prior to submission of papers to Board members
RF4	None identified	Board agenda and Board Report template specify the purpose of each paper.
RF5	None identified	Board Minutes attest to the challenge and scrutiny applied by members

3. Board insight and foresight ALB Name *Southern HSC Trust* Date *September 2023*

3.5 Assurance and risk management

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas where training or guidance is required and/or Areas were additional assurance is required
GP1	*The Board has developed and implemented a process for identification, assessment and management of the risks facing the ALB. This should include a description of the level of risk that the Board expects to be managed at each level of the ALB and also procedures for escalating risks to the Board.* **Evidence** Board Assurance Framework Risk Management Strategy Corporate and Directorate Risk Registers Board Minutes Governance Committee Terms of Reference	None required	Not applicable	None identified
GP2	*The Board has identified the assurance information they require, including assurance on the management of key risks, and how this information will be quality assured.* **Evidence** Board Assurance Framework The Senior Information Risk Officer (SIRO) is the Board member identified with lead	None required	Not applicable	None identified

	responsibility for providing assurance on the quality of data/information presented to the Board to support decision-making			
GP3	*The Board has identified and makes use of the full range of available sources of assurance, e.g. Internal/External Audit, RQIA, etc* **Evidence** A range of available sources of assurance are sought - RQIA, Internal/External, professional bodies etc. and reports to Governance Committee, Audit Committee, Performance Committee and Trust Board	None required	Not applicable	None identified
GP4	*The Board has a process for regularly reviewing the governance arrangements and practices against established Departmental or other standards e.g. the Good Governance Standard for Public Services.* **Evidence** Completion of Board Governance Self-Assessment Tool on annual basis Annual Internal Audit on Risk Management New structures for Corporate and Clinical and Social Care Governance Governance Committee Terms of Reference	None required	Not applicable	None identified

GP5	*The Board has developed and implemented a Clinical and Social Care Risk assessment and management policy across the ALB, where appropriate.* **Evidence** Risk Management Strategy Board Assurance Framework	None required	Not applicable	None identified
GP6	*An executive member of the Board has been delegated responsibility for all actions relating to professional regulation and revalidation of all applicable staff*. **Evidence** Executive Directors of Nursing, Midwifery and AHPs: Social Work and Medicine have responsibility for professional regulation and revalidation of all applicable staff	None required	Not applicable	None identified

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	None identified	Board Assurance Framework
RF2	None identified	Board assurance sources are identified via Risk Management process
RF3	None identified	Assurances are balanced across a range of sources
RF4	None identified	Board Governance Self-Assessments completed annually since 2013. Review of Corporate and Clinical and Social Care Governance arrangements undertaken

4. Board engagement and involvement ALB Name *Southern HSC Trust* Date *September 2023*

4.1 External stakeholders

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas where training or guidance is required and/or Areas were additional assurance is required
GP1	*Where relevant, the Board has an approved PPI consultation scheme which formally outlines and embeds their commitment to the involvement of service users and their carers in the planning and delivery of services.* **Evidence** PPI Consultation Scheme	None required	Not applicable	None identified
GP2	*A variety of methods are used by the ALB to enable the Board and senior management to listen to the views of service users, commissioners and the wider public, including 'hard to reach' groups like non-English speakers and service users with a learning disability. The Board has ensured that various processes are in place to effectively and efficiently respond to these views and can provide evidence of these processes operating in practice.* **Evidence** Working Together Strategy PPI Corporate Action Plan - progress updates provided at each Patient and Client Experience Committee meeting	None required	Not applicable	None identified

	Equality Scheme sets out how Trust will engage with a diverse range of groups/communities Regional interpreting Service PPI Panel membership on Patient and Client Experience Committee with PPI Panel member invited to provide update at each meeting			
GP3	*The Board can evidence how key external stakeholders (e.g. service users, commissioners and MLAs) have been engaged in the development of their business plans for the ALB and provide examples of where their views have been included and not included in the Business Plan.* **Evidence** The 2023/24 One Year Corporate Plan identifies that engagement with staff, service users, statutory partners and other stakeholders and wider community will take place on the development of the next Corporate Plan.	None required	Not applicable	None identified
GP4	*The Board has ensured that various communication methods have been deployed to ensure that key external stakeholders understand the key messages within the Business Plan.* **Evidence** See GP3.	None required	Not applicable	None identified

	Public attendance at Board meetings			
GP5	*The Board promotes the reporting and management of, and implementing the learning from, adverse incidents/near misses occurring within the context of the services that they provide* **Evidence** Clinical and Social Care Governance Report to Governance Committee Learning from Experience Forum	None required	Not applicable	
GP6	*The ALB has constructive and effective relationships with its key stakeholders.* **Evidence** Attendees list - actively encourage key stakeholders to attend Trust Board meetings All public consultations include communication/engagement plan External relationships are maintained on an ongoing basis with MLAs, local Councils Community Planning Social Media Policy – Facebook, Twitter and UTube page for development of digital media	None required	Not applicable	

	Proactive Media Planner to promote developments and news across the Trust			

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	None identified	The Corporate Plan is widely consulted on both internally and externally
RF2	None identified	The Trust continues to work on maintaining good relationships with external stakeholders, clients, client organisations etc.
RF3	None identified	Feedback from complaints, surveys and findings from regulatory and review reports is used to inform the Business Planning process
RF4	None identified	None
RF5	None identified	Developing format to incorporate implementation of learning from complaints through exisiting workstreams/quality improvement framework

4. Board engagement and involvement ALB Name *Southern HSC Trust* Date *September 2023*

4.2 Internal stakeholders

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas where training or guidance is required and/or Areas were additional assurance is required
GP1	*A variety of methods are used by the ALB to enable the Board and senior management to listen to the views of staff, including 'hard to reach' groups like night staff and weekend workers. The Board has ensured that various processes are in place to effectively and efficiently respond to these views and can provide evidence of these processes operating in practice.* **Evidence** Regional Staff Survey (Trust specific results) Facebook, Twitter and U Tube Southern i Leadership Waks Quality Improvement Strategy Quality Improvement Newsletter Consultation Engagment Plans Development of People Framework 2022-25 has been as a result of a range of staff engagement initiatives	None required	Not applicable	None identified

GP2	*The Board can evidence how staff have been engaged in the development of their Corporate & Business Plans and provide examples of where their views have been included and not included.* **Evidence** Corporate objectives were developed via staff engagement process	None required	Not applicable	None identified
GP3	*The Board ensures that staff understand the ALB's key priorities and how they contribute as individual staff members to delivering these priorities.* **Evidence** Leadership Walks Southern i	None required	Not applicable	None identified
GP4	*The ALB uses various ways to celebrate services that have an excellent reputation and acknowledge staff that have made an outstanding contribution to service delivery and the running of the ALB.* **Evidence** Good news stories reported via Chair's business at Trust Board meetings Southern i Proactive communication planner (Quarterly) highlighting events/successes/developments across the Trust	None required	Not applicable	None identified

	Service Improvement/Staff and Service User feedback at start of Trust Board meetings Annual Quality Improvement Event			
GP5	*The Board has communicated a clear set of values/behaviours and how staff that do not behave consistent with these valves will be managed. Examples can be provided of how management have responded to staff that have not behaved consistent with the ALB's stated values/behaviours.* **Evidence** HSC Values Code of Conduct Board Behaviours Monthly Case Management Report Working Well Together Policy Whistleblowing Policy People Management Framework GREATix	None required	Not applicable	None identified

GP6	*There are processes in place to ensure that staff are informed about major risks that might impact on customers, staff and the ALB's reputation and understand their personal responsibilities in relation to minimising and managing these key risks.* **Evidence** Corporate and Directorate Risk Registers communicated via cascaded engagement with Directorates	None required	Not applicable	None identified

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	None identified	
RF2	None identified	There are no unresolved staff issues that are significant
RF3	None identified	There are no significant unresolved quality issues
	None identified	Workforce issues are included in HR Report to Trust Board.
	None identified	Best practice is shared within the Trust via a variety of means e.g. Trust Board, Committees. Southern i, Continuous Improvement etc.

4. Board engagement and involvement ALB Name *Southern HSC Trust* Date *September 2023*

4.3 Board profile and visibility

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas where training or guidance is required and/or Areas were additional assurance is required
GP1	*There is a structured programme of events/meetings that enable NEDs to engage with staff (e.g. quality/leadership walks; staff awards, drop in sessions) that is well attended by Board members and has led to improvements being made.* **<u>Evidence</u>** Non Executive Directors Visits Report to Governance Committee Non Executive Director Children's Homes visits report to Governance Committee Active participation at events Trust Board meetings – attendance of staff and Assistant Directors	None required	Not applicable	None identified

GP2	*There is a structured programme of meetings and events that increase the profile of key Board members, in particular, the Chair and the CE, amongst external stakeholders.* **Evidence** The Chair and Chief Executive undertake and attend a variety of events, details of which are provided on a monthly basis in Chair and Chief Executive's business to Trust Board.	None required	Not applicable	None identified
GP3	*Board members attend and/or present at high profile events.* *Active participation at high profile events.* **Evidence** All events, seminars, workshops attended by NEDs are listed in the Chair and NED business to Trust Board on a monthly basis.	None required	Not applicable	None identified
GP4	*NEDs routinely meet stakeholders and service users.* Non Executive Director visits Children's Homes visits Trust Board Young People's Pledge Attendance at wide range of events	None required	Not applicable	None identified

GP5	*The Board ensures that its decision-making is transparent. There are processes in place that enable stakeholders to easily find out how and why key decisions have been made by the Board without reverting to freedom of information requests.* **Evidence** Trust Board agenda and minutes and papers publically available on Trust website Record of Public attendance at Board meetings	None required	Not applicable	None identified
GP6	*As a result of the Board member appraisal and personal development process, Board members can evidence improvements that they have made in the quality of their contributions at Board-level.* **Evidence** Board Reports Board Minutes Annual Appraisals	None required	Not applicable	None identified

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	None identified	See Good Practice GP1 – GP6 – there are a range of processes in place to raise the profile and visibility of the Board
RF2	None identified	High attendance by Board members at events/meetings

Summary Results **ALB Name** ***Southern HSC Trust*** **Date September 2023**

1.Board composition and commitment		
Area	Self Assessment Rating	Additional Notes
1.1 Board positions and size	Amber/Green	Department led Recruitment exercise for SH&SCT Non Executive Directors underway
1.2 Balance and calibre of Board members	Green	
1.3 Role of the Board	Green	
1.4 Committees of the Board	Green	New structures for corporate and clinical and social care governance to be embedded during 2023/24.
1.5 Board member commitment	Green	

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

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

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