Department of
Health, Social Services and Public Safety
www.dhsspsni.gov.uk

BOARD GOVERNANCE SELF ASSESSMENT TOOL

For use by DHSSPS Sponsored Arms Length Bodies

Submission by South Eastern H&SC Trust
(completed as at 1 December 2018, approved by Governance Assurance Committee 19/12/18
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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 CIPFA). 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 DHSSPS 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, Social Services and Public Safety (DHSSPS).

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.

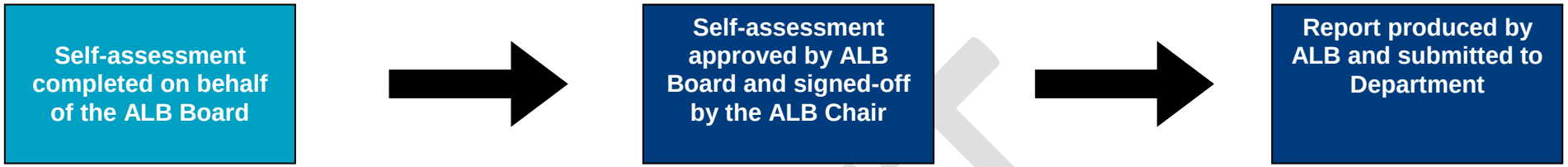
Refer to the scoring criteria identified on page 7 to apply self assessment ratings.

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.

Report produced: The ALB Board should provide a report back to Department's Central ALB Governance Unit (CAGU). This report should include the self-assessment ratings reached by the ALB Board and, where necessary, provide details on action plans on how they are going to comply with best practice.

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 and subsequently to the Department. This report will include their independent view on the accuracy of the Board's ratings and where necessary, provide recommendations for improvement. The Department may also wish to explore options at its disposal to ask for its own independent verification.

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 (pg 10-37) using the electronic Submission Document (pg 39-60). 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 (pg 61-62) 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 3 mini case studies (pg 65-68) on;

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

The Board should use the electronic template provided and the case studies 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 studies. 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.

The Report

The ALB will provide a summary report (see proforma) to the Department which will comprise of:

1. the self-assessment ratings reached by the ALB Board;
2. a brief description of the action plans that will be implemented to ensure compliance with Best Practice;
3. areas where the Board believes additional assurance is required; and
4. their feedback on the self-assessment and any suggested areas for improvement (e.g. identify specific criteria that need tweaked).

Replies to:

Central Arm's Length Bodies Governance Unit

Room D3

Castle Buildings

Stormont

BT4 3SQ

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 2 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 CIPFA "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 accoun
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 within the last two years.	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. 5. The Board has not overseen a system for receiving, acting on and reporting	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.

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 South Eastern Health & Social Care Trust

Date of Board Meeting at which Submission was discussed…….....(~~28 March 2018~~20 March 2019)

Approved by ……..... (Mr Colm McKenna, Chairman as at 28 February 2019)

1. Board composition and commitment ALB Name: South Eastern HSC Trust Date: 20 March 2019

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 were training or guidance is required and/or Areas were additional assurance is required
GP1	Standing Orders (including SFIs) – last updated Jan & August 2017 HSS Trusts (Membership Procedures) Regulations NI 1996 SET Establishment Order 1996 Board Minutes Job Descriptions Biographical information on each member of the Board	None required	Not Applicable	None identified
GP2	Standing Orders (including SFIs) HSS Trusts (Membership Procedures) Regulations NI 1996 SET Establishment Order 1996 HSC Reform Act 2009 – Framework Document Management Statement/ Financial Memorandum – last update November 2017	None required	Not Applicable	None identified
GP3	Standing Orders (including SFIs) HSS Trusts (Membership	None required	Not Applicable	None identified

	Procedures) Regulations NI 1996			
GP4	Standing Orders (including SFIs) HSS Trusts (Membership Procedures) Regulations NI 1996 SET Establishment Order 1996	None required	Not Applicable	None identified
GP5	Letters of appointment by DHSSPS	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/CE posts are filled
RF2	None identified	Membership of Trust Board has changed following recent recruitment exercise by DoH for new NEDs therefore the red flag issue does not apply in this instance. A new Director of HR & CA was appointed on 14/3/2016. Three new NEDs were appointed on 15 and 22 February 2016 respectively. A further four new NEDs were appointed wef 1 Janaury 2017. One NED left on 7/9/18.
RF3	None identified	All Trust Board meetings are quorate. Non-attendance at meetings is by agreement with the Chairman and always for a valid reason.

1. Board composition and commitment ALB Name: South Eastern HSC Trust Date: 20 March 2019

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 were training or guidance is required and/or Areas were additional assurance is required
GP1	Board Skills Audit ~~)~~ Appraisals of CE /Directors Allocation of NEDs to sub committees on the Board based on their skills, experience and knowledge Current balance of skills deemed appropriate	Trust Board consider existing skill set is appropriate. A skills audit of Board members was last issued on 20/2/14. This informed the content of the Board Development Programme for 2015/16 and beyond and the Induction Programme for new Non-Executive Directors post in 2016/17. A skills audit was completed in April 2018 and has informed the Board Development Programme for 2018/19.	Not applicable	None identified
GP2	Yes – there is a range of backgrounds from the public and private sectors on the Trust Board (none from voluntary sector appointed) Declaration/Register of Interests	None required	Not applicable	None identified
GP3	Yes – all members are aware of the Equality Legislation. In addition the Equality Scheme features on a regular basis on the Trust Board agenda. Board minutes Equality Training undertaken,	None	Not applicable	None identified

	as appropriate Trust Board Workshop covering Equality issues			

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 were training or guidance is required and/or Areas were additional assurance is required
GP4	All new NEDs have relevant backgrounds to undertake their appointed roles. Note – it should be noted that the Public Appointments process does not ask for candidates to submit qualifications as this is seen as prohibiting the type of people and the diversity the Commissioner's office is promoting. However, they are appointed based on their answers to a criteria based interview. The use of a skills audit for NEDs assists in development of a comprehensive Board Development programme. A bespoke Induction programme is als0 helpful.	None required	Not applicable	None identified
GP5	Biographical information on each member of the Board Job Descriptions – Directors	None required	Not applicable	None identified
GP6	Board Members – there is an appropriate balance of Directors and NEDs that are new to the Board (ie, within their first 18 months) and those that have served on the Board	None required.	Not applicable	None identified

	for longer.			
GP7	Job Descriptions of Directors Biographical Information for Board members	None required	Not applicable	None identified
GP8	Yes – the Chairman of the Board has a demonstrable and recent track record of working in a large and complex organisation.	None required	Not applicable	None identified
GP9	No – the Chairman does not have previous Non Executive experience however this was not a requirement of the appointments process	Not applicable – Chairman already in post	The Chairman does not have previous Non Executive experience however this was not a requirement of the appointments process.	None identified
GP10	Yes –Mr Bradyhas recent and relevant financial experience and is a member of the Audit Committee	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	One new NED – Mr Noel Brady appointed as the Finance member of the Non-Executive Director team.
RF2	None identified	NEDs with current or recent (within previous 2 years) in the private /commercial sector –, Mr Brady, Mr Mawhinney and Mr Patton
RF3	None identified	All NEDs have previous relevant experience
RF4	None identified	Three x new NEDs (appointed in Feb 2016) and 2 x new Directors (April 2015 and March 2016). A further 4 new NEDs appointed in January 2017. 1 NED left on 7/9/18 and a replacement is awaited.
RF5	None identified	The balance of Directors/Non Executive is correct
RF6	None identified	Three new NEDs appointed wef 15 & 22 February 2016. Four new NEDs appointed wef 1 January 2017. 1 NED left on 7/9/18 and a

		replacement is awaited.

1. Board composition and commitment ALB Name: South Eastern HSC Trust Date: 20 March 2019

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 were training or guidance is required and/or Areas were additional assurance is required
GP1	Induction Programme Job descriptions Code of Conduct & Accountability Board Assurance Framework Management/Financial Statement H&S Care Reform Act 2009 – Framework Document Management Statement/ Financial Statement	None required	Not applicable	None identified
GP2	Code of Conduct & Accountability Board Assurance Framework Management/Financial Statement H&S Care Reform Act 2009 – Framework Document Management Statement/ Financial Statement	None required	Not applicable	None identified
GP3	Job descriptions Code of Conduct & Accountability Board Assurance Framework Management/Financial Statement	None required	Not applicable	None identified

	H&S Care Reform Act 2009 – Framework Document Management Statement/ Financial Statement			
GP4	Job descriptions Code of Conduct & Accountability Board Assurance Framework Management/Financial Statement H&S Care Reform Act 2009 – Framework Document Management Statement/ Financial Statement	None required	Not applicable	None identified
GP5	Yes – NEDs are independent of management	None required	Not applicable	None identified
GP6	Yes – the Chair hada positive relationship with the former Minister and looks forward to continuity this when the Executive returns to Stormont	None required	Not applicable	None identified
GP7	Board minutes Monthly Performance Improvement Meetings CE Mid and End of Year Accountability Meetings Ground Clearing meetings	None required	Not applicable	None identified
GP8	Board minutes Trust BoardMeetings / workshops	None required	Not applicable	None identified
GP9	Board Minutes	None required	Not applicable	None identified
GP10	Board Minutes	None required	Not applicable	None identified

	Confidential Board Minutes SIRO (Director of HR & CA)			
GP11	Board Minutes	None required	Not applicable	None identified
GP12	Board Minutes Confidential Board Minutes	None required	Not applicable	None identified
GP13	Chairman of the Board Board Minutes Confidential Board Minutes Individual meetings with NEDs 1-1 appraisals	None required	Not applicable	None identified
GP14	Board Minutes Confidential Board Minutes	None required	Not applicable	None identified
GP15	Consultation Schemes managed via the Strategic & Capital Development Directorate Board Minutes Staff Survey	None required	Not applicable	None identified
GP16	Scheme of Delegation is contained within the Standing Orders which is reviewed on an annual basis	Standing Orders are reviewed on an annual basis –last updated in January and August 2017	Not applicable	None identified
GP17	This function of PPE is delegated to the Finance Committee which is a sub committee of the Board Minutes of the Finance Committee	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	Via Trust Board Minutes
RF2	None identified	Via Trust Board Minutes
RF3	None identified	Via Trust Board Minutes
RF4	None identified	Via Trust Board Minutes
RF5	None identified	Via Trust Board Minutes

RF6	None identified	Via Trust Board Minutes

1. Board composition and commitment ALB Name: South Eastern HSC Trust Date: ~~28 March 2018~~20 March 2019

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 were training or guidance is required and/or Areas were additional assurance is required
GP1	TOR for all Sub Committees of Trust Board approved by Trust Board Board Minutes Schemes of delegation	None required	Not applicable	None identified
GP2	TOR for all Sub Committees of Trust Board approved by Trust Board Board Minutes Schemes of delegation	None required	Not applicable	None identified
GP3	TOR for all Sub Committees of Trust Board approved by Trust Board Board Minutes Schemes of delegation	None required	Not applicable	None identified
GP4	TOR for all Sub Committees of Trust Board approved by Trust Board Board Minutes Schemes of delegation Governance High Level Organisational Chart	None required	Not applicable	None identified
GP5	TOR for all Sub Committees of Trust Board approved by Trust	None required	Not applicable	None identified

	Board Board Minutes Schemes of delegation			
GP6	All minutes of Board Sub Committees are circulated with the papers for the next scheduled Trust Board meeting. They are presented for information/noting by the appropriate Chairperson who will highlight issues on an exception basis, as appropriate. A short cover report is provided with each set of minutes highlighting key items discussed at the meeting.	None required	Not applicable	None identified
GP7	Evaluation reports of the effectiveness of Trust Board Sub Committees – Audit, Governance Assurance	This practice has already been adopted by the Trust Board in 2012 and was extended to the Finance, Charitable Funds and Remuneration Committees in 2013/2014.	This practice will be extended to the Finance & Performance Committee in ~~2017/18~~2018/19. N/A for Remuneration Committee.	None identified
GP8	TOR for Sub Committees Chairperson of Sub Committees	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 meetings presented by relevant Committee Chairman and reports made on an exception basis
RF2	None identified	NED appraisals include discussion on any sub committees they chair
RF3	None identified	There are TORs for all Board Sub Committees
RF4	None identified	NEDs are fully aware of the differing roles between the Board and Committee
RF5	None identified	Draft agendas for Board Sub Committees is drafted by the Board

		Secretary with input from Directors, as required, prior to approval by the Chairperson

1. Board composition and commitment ALB Name: South Eastern HSC Trust Date: 20 March 2019

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 were training or guidance is required and/or Areas were additional assurance is required
GP1	Board attendance records contained in the Board Minutes Board attendance records contained in Sub Committee Minutes High level register of attendance for Directors & NEDs at all Trust Board and Trust Board Sub Committtees held Trust Board workshops & Development programme	None required	Not applicable	None identified
GP2	Non-Executive Directors – 1 day per week Chairman – 3 days per week Induction Programme Attend Trust Board meetings, sub committee, workshops, Away Days, Visits to Children's Homes, Environmental Visits	None required	Not applicable	None identified
GP3	All Trust Board members received the Code of Conduct and Accountablity on the 19 July 2012 (by email from the Chairman) and on appointment for those appointed thereafter	None required	Not applicable	None identified

	Annual check of compliance signed by all Trust Board members (December of each year) Compliance with code is monitored by Chair as part of each member's annual appraisal			
GP4	Schedule of Board and Sub Committee meetings prepared and issued in August each year	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	Yes – Board and Sub Committee minutes
RF2	None identified	No – all non attendance at Board meetings and Sub Committees is reviewed by the Chair and valid reasons for non attendance are provided
RF3	None identified	All members attend Board and Sub Committee meetings as required. If unable to attend explanation provided to the Chair in advance of the meeting.
RF4	None identified	Board members behave as per the Code of Conduct and Accountability
RF5	None identified	Attendance at Board and Committee meetings is reviewed on a regular basis and is included in the report of effectiveness of sub committees which is submitted to the Board.

2. Board evaluation, development and learning ALB Name: South Eastern HSC Trust Date: 20 March 2019

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 were training or guidance is required and/or Areas were additional assurance is required
GP1	Review of the Corporate Govenance Code for Central Government Departments – Code of Good Practice & Guidance (Dec 2014) Scheme of Delegation/ Reservation of Powers Report on the outcome on the most recent Board Governance Self Assessment Tool evaluation and examples of changes/improvements made in the Board and Committees as a result of the evaluation (completed during Jan/Feb 2015 presented to the Trust Board for approval on 25/3/15. Report of 2nd Independent Evaluation presented to Trust Board on 28/3/18 for approval. 2012/13 completed BGSAT 2013/14 completed BGSAT	6th year BGSAT completed and presented to Trust Board workshop on 7/12/17 for endorsement and Trust Board meeting for approval on 28/3/18. 2nd three year assessment includes Independent Verification by external consultant (via HSC Leadership Centre)	Not applicable	None identified

	2014/15 completed BGSAT (plus Independent Verification) 2015/16 completed BGSAT 2016/17 completed BGSAT 2017/18 completed BGSAT (plus Independent Verification) 2018/19 completed BGSAT Internal Audit of Board Effectiveness 2013/14 and 2016/17			
GP2	Changes/improvements recommended in the above review (at GP1) have been implemented and signed off by the Governance Assurance Committee and reported to the Trust Board Report on the outcome on the most recent Board Governance Self Assessment Tool evaluation and examples of changes/improvements made in the Board and Committees as a result of the evaluation (completed during Jan/Feb 2015 presented to the Trust Board for approval on 25/3/15. Report of 2nd Independent Evaluation presented to Trust Board on 28/3/18 for approval. Internal Audit of Board Effectiveness 2013/14 and 2016/17	None required	Not applicable	None identified

GP3	Review of the Corporate Govenance Code for Central Government Departments – Code of Good Practice & Guidance (Dec 2014) Scheme of Delegation/ Reservation of Powers Report on the outcome on the most recent Board Governance Self Assessment Tool evaluation and examples of changes/improvements made in the Board and Committees as a result of the evaluation (completed during Jan/Feb 2015 presented to the Trust Board for approval on 25/3/15. Report of 2nd Independent Evaluation presented to Trust Board on 28/3/18 for approval. Internal Audit of Board Effectiveness 2013/14 and 2016/17	None required	Not applicable	None Identified
GP4	Staff Surveys Patient/Client Surveys Patient/Client Stories DoH Accountability Review Meetings Staff Survey -2015 (next survey	None required	The Trust will seek to futher expland its evaluation methods and, in particular, to cosider the perspective of a representative sample of staff and key external stakeholders (eg, commissioners, service users and clients) on	None identified

	planned 2019 – possible that a cultural survey will be done pre 2019) Individual Director meetings with Department and HSCB representatives		whether they consider the Board to be effective.	
GP5	Review of the Corporate Govenance Code for Central Government Departments – Code of Good Practice & Guidance (Dec 2014) Scheme of Delegation/ Reservation of Powers Report on the outcome on the most recent Board Governance Self Assessment Tool evaluation and examples of changes/improvements made in the Board and Committees as a result of the evaluation (completed during Jan/Feb 2015 presented to the Trust Board for approval on 25/3/15. Report of 2nd Independent Evaluation presented to Trust Board on 28/3/18 for approval.	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	First BGSAT undertaken in 2012/13 (approved by Trust Board on 27/3/13) Second BGSAT undertaken in 2013/14 (approved by Trust Board on 26/3/14) Third BGSAT undertaken in 2014/15 (approved by Trust Board 25 March 2015) (included Independent Evaluation) Fourth BGSAT undertaken in 2015/16 (approved by Trust Board on 23/3/16) Fifth BGSAT undertaken in 2016/17 (to be approved by Trust Board on 29 March 2017) Sixth BGSAT undertaken in 2017/18 (to be approved by Trust Board on 28 March 2018 Seventh BGSAT undertaken in 2018/19 (to be approved by Trust Board on 20 March 2019)
RF2	None identified	Independent Evaluation completed by an Associate, HSC Leadership Centre, February/March 2015 Independent Evaluation completed by an Associate, HSC Leadership Centre, Jan – March 2018
RF3		Independent Evaluation completed by an Associate, HSC Leadership Centre, February/March 2015 and includes perspectives other than Board members but requires more input from other sources as per the guidance. 2nd Independent Evaluation completed Jan 2018 and includes perspectives other than Board members. For example the results of the Staff Survey provide a gendal expression of confidence in the organisation. Also, regular meetings with the DoH (-Accountability Meetings – Chair/CE), meetings with HSCB/PHA etc.
RF4	None identified	Independent Evaluation completed by an Associate, HSC Leadership Centre, February/March 2015 and includes more than one evaluation method ie, meetings with Chairman, NEDs, Board Secretary, Lead Director of Governance, attendance at Trust Board

		meetings, desktop review of relevant papers. 2nd Independent Evaluation completed Jan 2018 and includes perspectives other than Board members. For example the results of the Staff Survey provide a gendal expression of confidence in the organisation. Also, regular meetings with the DoH (- Accountability Meetings – Chair/CE), meetings with HSCB/PHA etc.

2. Board evaluation, development and learning ALB Name: South Eastern HSC Trust Date: 20 March 2019

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 were training or guidance is required and/or Areas were additional assurance is required
GP1	On Board Programme (attended by all NEDs appointedin 2016/2017) Five day Development Programme on appointment (NEDs 2007 -2017) Attendance Records at development programmes – internal and external Trust Board workshops Trust Board Away Days Formal Board Development Programme in place for 2014/15,2015/16 and 2016/17 programme. Updated for April 2015 – March 2020. Report on the Skills Audit, January 2015 Report of Skills Audit, A0pril 2018.	None required	Not applicable	None identified
GP2	Code of Conduct & Accountability Board Assurance Framework	None required	Not applicable	None identified

	Management/Financial Statement H&S Care Reform Act 2009 – Framework Document			
GP3	Review of Goverance Arrangements – March 2012 Internal Audit Reports – Risk Management & Governance SAI reports Statement of Internal Control Review of the Corporate Govenance Code for Central Government Departments – Code of Good Practice & Guidance (Dec 2014) Lessons Learnt Sub Committee	None required	Not applicable	None identified
GP4	Review of the Corporate Govenance Code for Central Government Departments – Code of Good Practice & Guidance (Dec 2014) Report on the outcome on the most recent Board Governance Self Assessment Tool evaluation and examples of changes/improvements made in the Board and Committees as a result of the evaluation (completed during Jan/Feb 2015 presented to the Trust Board for approval on 25/3/15. Report of 2nd	None required	Not applicable	None identified

	Independent Evaluation presented to Trust Board on 28/3/18 for approval.			
GP5	Time is allowed for attendance at development programmes within the days allocated to NEDs	None required	Not applicable	None identified
GP6	Via Trust Board workshops Formal Board Development Programme in place for 2014/15, 2015/16 and 2016/17. Updated for April 2015 – March 2020. Report on the Skills Audit, January 2015	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	All NEDs have attended the On Board Programme. Formal Trust Board Development Programme in place from April 2015/16 to March 2020. Previous programme in place wef from February 2013 – March 2015). Last Skills Audit completed in January 2015 and will be redone at an appropriate time – ie post January 2018.
RF2	None identified	None required

2. Board evaluation, development and learning ALB Name: South Eastern HSC Trust Date: 20 March 2019

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 were training or guidance is required and/or Areas were additional assurance is required
GP1	Induction Programmes – Directors NED 5 Day Induction Programme (2007-2017) NED x 1 day Induction programme & pack On Board Programme (for NEDs appointed in 2016/2017) Buddy System in place for NEDs with a named Director Meetings with key staff Standing Orders Board Development Plan Board Skills Auidt	None required	Not applicable	None identified
GP2	Induction Programmes NED 5 Day Induction Programme (2007-2017) NED x 1 day Induction programme & pack On Board Programme (for NEDs appointed in 2016/2017 Buddy System in place for NEDs with a named Director Meetings with key staff Standing Orders Board Development Plan	None required	Not applicable	None identified

	Board Skills Auidt			
GP3	Induction Programmes NED 5 Day Induction Programme (2007-2017) NED x 1 day Induction programme & pack Buddy System in place for NEDs with a named Director Meetings with key staff Standing Orders Board Development Plan Board Skills Auidt	None required	Not applicable	None identified
GP4	Appropriate deputising arrangements are put in place when the CE and Chair are not available	None required	Not applicable	None identified
GP5	Succession Planning for new Directors Discussions, held on resignation/retirement of Directors, on the skills required to govern the organisation effectively in the future and the implications of key Board-level leaders leaving the organisation	Director of Adult Services & PHC took up post on 1 April 2015. Director of HR & CA retired on 29/2/16. New Director HR & CA took up post on 14/3/16.	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	All NEDS have attended the On Board programme (June 2016/March 2017).
RF2	None identified	There are arrangements contained in the Standing Orders for chairing Board meetings (and committee meetings) if the Chair is

		not available
RF3	None identified	Arrangements now documented in SO & SFIs in respect of how organisation is to be represented at a senor level at Board meeting if the CE is unavailable.
RF4	None identified.	-

2. Board evaluation, development and learning ALB Name: South Eastern HSC Trust Date: 20 March 2019

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 were training or guidance is required and/or Areas were additional assurance is required
GP1	Performance appraisal takes place for all NEDs and Directors	None required	Not applicable	Any issues identified as a consequence of appraisal are taken forward
GP2	Performance appraisal takes place for all Directors by the Chief Executive	None required	Not applicable	None identified
GP3	Performance appraisal of Chair by Deputy Secretary /countersigned by Permanent Secretary	None required	Not applicable	None identified
GP4	Performance appraisal for all NEDs Performance appraisal for all Directors which addresses personal development needs Objectives set for Directors by CE In the case of the CE this is undertaken by the Chairman	– None required	- Not applicable	None identified
GP5	Performance appraisal for all NEDs Performance appraisal for all Directors which addresses personal development needs	- – None required	Not applicable	None identified

	In the case of the CE this is undertaken by the Chairman			
GP6	Performance appraisal, including Personal Development Plans, for all Directors	None required	Not applicable	
GP7	Board Minutes that evidence Executive Directors contributing outside their functional role and challenging other Executive Directors	None required	Not applicable	None identified
GP7	Evidence of attendance at training events and conferences Professional Codes of Conduct Continuing Professional Development/IPD portfolios	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	Formal training and development and/or professional development is encouraged and in operation
RF3	None identified	Appraisals are undertaken in a timely fashion and are encouraged
RF4	None identified	The Chairman fully considers the differing roles of Board members and Committee members when undertaking appraisals. He assigns NEDs to committees on the basis of their individual business strengths.

3. Board insight and foresight ALB Name: South Eastern HSC Trust Date: 20 March 2019

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 were training or guidance is required and/or Areas were additional assurance is required
GP1	Board Performance Reports – Finance, Performance and SQE Board Minutes Lessons Learned	None required	Not applicable	None identified
GP2	Board Performance Reports – Finance, Performance and SQE Board Minutes Lessons Learned	None required	Not applicable	None identified
GP3	Board Minutes Board Agendas and Minutes highlighting committee discussions (-All sub committee complete a report which is presented by the respective Chair at the next Trust Board meeting in respective of the work of the their respective sub committees))	None required	Not applicable	None Identified
GP4	Board Minutes and papers Board Assurance and Corproate Risk Register Reports	None required	Not applicable	None identified
GP5	Board Action Log circulated	None required .	Not applicable	None identified

	following Trust Board meetings (includes date/person allocated) and followed up by Board Secretary			

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 identify 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, Quality and SQE reports considered together. Also Risk Management, SAIs and Lessons Learned reports
RF4	None identified	Regular and timely financial information is provided to the Board including cash flow forecast information. Action Logs held by respective area/s as required. The Trust Board has an action log for actions arising out of Trust Board meetings
RF5	None identified	The Board receives sub committee minutes which are reported on an exception basis. Key risks are reported/escalated to the Board as and when required via formal reports and verbal reports by Directors

3. Board insight and foresight ALB Name: South Eastern HSC Trust Date: 20 March 2019

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 were training or guidance is required and/or Areas were additional assurance is required
GP1	Trust Delivery Plan (includes efficiency and productivity plans) Financial Strategy/Plan Monthly Performance Reports, Dashboad and Scorecards to Trust Board -Reform Board (oversees all Reform & Modernisation at executive level in Trust including former TYC programme; Minister's Vision – Delivering Together) Risk Register on EPM reported to EPM and highlighted to Trust Board on an exception basis Consultation workshops re saving plans 2017/18 and outcome reports CHKS Information Monthly Performance Management Meetings New Monthly Finance Performance Review Meetings Post Implementation Reviews	Not applicable	Not applicable	None identified

	(delegated to Finance Committee) Accountability Reviews - biannual basis Accountability Reviews – external with DoH Papers to Committees SQE Programmes Board Assurance Framework			
GP2	-Reform Board (oversees all Reform & Modernisation at executive level in Trust including former TYC programme; Minister's Vision – Deliverying Together) Risk Register on EPM reported to EPM and highlighted to Trust Board on an exception basis Consultation workshops re saving plans 2017/18 and outcome reports	Not applicable	Not applicable	None identified
GP3	Trust Delivery Plan (includes efficiency and productivity plans) Financial Strategy/Plan Monthly Performance Reports, Dashboad and Scorecards to Trust Board -Reform Board (check name with HM) (oversees all Reform	Not applicable	Not applicable	None identified

	& Modernisation at executive level in Trust including former TYC programme and Minister's Vision – Delivering Together) Risk Register on EPM reported to EPM and highlighted to Trust Board on an exception basis Consultation workshops re saving plans 2017/18 and outcome reports CHKS Information Monthly Performance Management Meetings Introduction of new Monthly Finance Performance Review Meetings Post Implementation Reviews (delegated to Finance Committee) Accountability Reviews - biannual basis Accountability Reviews – external with DoH Papers to Committees SQE Programmes Board Assurance Framework -. Regular reports on this activity are included in the monthly performance and finance reporting. Accountability meetings			

GP4	- Post Incident Reviews Accountability Review HSCB and DoH meetings	Not applicable	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 is the EPMB and Risk Registers are held on EPM system
RF3	None identified	The Population Plan is based on TYC and other update plans and includes plans for service provision requirements which take account of projected demand and capacity
RF4	None identified	There is a Board Assurance Framework which is updated on a regular basis

3. Board insight and foresight ALB Name: South Eastern HSC Trust Date: 20 March 2019

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 were training or guidance is required and/or Areas were additional assurance is required
GP1	CE report Board Assurance/CRR report Board Minutes	None required	Not applicable	None identified
GP2	Lessons Learnt Sub Committee Minutes Reports of Statutory Functions Board Minutes Key reports for eg, Francis Report etc	None required	Not applicable	None identified
GP3	Business Planning Workshops Leadership Conferences Outcomes of external stakeholder mapping exercise	None required	Not applicable	None identified
GP4	Business Planning Workshops Leadership Conferences Corporate Plan 2017-2021 Performance Reports to Trust Board re objectives	Not applicable	Not applicable	None identified
GP5	Informal Programme of Work for the Board Board Assurance Framework/ Corporate Risk Register Report to the Trust Board – twice per year Corporate Risk Register Documented TOR (including	~~Develop a documented programme of work for the Board (draft document with Chair for approval)~~ Not applicable	Not applicable	None identified

	programme of work) for the Trust Board (sept 2018)			

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 very clear understanding of Executive/Departmental priorities and its statutory responsibilities, business plan etc
RF2	None identified	The Board has a programme of work and regularly considers environmental and strategic risks
RF3	None identified	The Board regularly reviews progress relating to its key strategies

3. Board insight and foresight ALB Name: South Eastern HSC Trust Date: 20 March 2019

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 were training or guidance is required and/or Areas were additional assurance is required
GP1	Schedule of Board and Committee meetings taking account of month and year end procedures and key dates Internal procedures are planned to take account of this schedule Planning process takes account of relevant Trust Board approvals required in line with DoH schedule.	None required	Not applicable	None identified
GP2	Timetable in place of issue of Board and its sub committee papers Board meeting timetable	None required	Not applicable	None identified
GP3	Each paper submitted to the Board clearly states action required for eg, noting, approving, discussion or decision Process for submitting and issuing Board Papers	None required	Not applicable	None identified

GP4	Performance Reports Process for alerting NEDs to key significant issues outside of meeting dates by email communications	None required	Not applicable	None identified
GP5	Board papers indicate actions required at meeting	None required		
GP6	CHKS reports Finance, Performance & SQE Reports Mortality Reports Coding Reports to Accountability Review Programme of Clinical Audit and Internal Audit Reports	None required	Not applicable	None identified
GP7	Discussion at Monthly Performance Monitoring Meetings Discussions at monthly Trust Board meetings – in particular Performance Dashboard which includes areas of good performance Accountabilty Reviews	None required	Not applicable	None identified
GP8	CHKS reports Finance, Performance & SQE Reports Mortality Reports Coding Reports to Accountability Review	None required	Not applicable	None identified

	Programme of Clinical Audit and Internal Audit Reports Infrormatics Strategy The Board can ask for ad hoc reports, as required			
GP9	Challenge function of NEDs via Board minutes. Decision making agreed	None required	Not applicable	None identified
GP10	Documentation presented to the Board complies with Departmenal 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 on Trust IPads one week in advance of meeting
RF2	None identified	Board discussions focus on understanding of issues so decision making is properly informed
RF3	None identified	Data quality is checked and validated prior to submission of Board papers
RF4	None identified	Board agenda /papers specify the purpose of papers for eg, for approval, discussion, information/noting etc
RF5	None identified	Board minutes record challenges where this occurs

3. Board insight and foresight ALB Name: South Eastern HSC Trust Date: 20 March 2019

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 were training or guidance is required and/or Areas were additional assurance is required
GP1	Risk Management Strategy, Policies and Procedures Risk Registers – Corporate and Directorate level Evidence of review of risks in Board Minutes Assurances required is detailed in CRR pro forma	None required	Not applicable	None identified
GP2	Assurances required by Board detailed in CRR pro forma	None required	Not applicable	None identified
GP3	Board has a range of assurances – Internal/External, RQIA, professional bodies etc	None required	Not applicable	None identified
GP4	Board Minutes Baseline assessments (eg, Western Trust, NIAO document on Risk Management) Review of Governance Infrastructure (March 2010 and annually thereafter) Governance Strategy BGSAT, 2013, 2014 2015, 2017 and 2017 with Independent Evaluation every 3 years (ie, 2015 and 2018; next	None required – continue to ensure Independent Evaluation is completed on a 3 yearly cycle	Not applicable	None identified

	IE due in 2021) Review of governance arrangements using the Review of the Corporate Govenance Code for Central Government Departments – Code of Good Practice & Guidance (Dec 2014) Annual Internal Audit on Risk Management & Governance			
GP5	Board Assurance Framework Governance Strategy	None required	Not applicable	None identified
GP6	Risk Assessment policy – general and clinical and social care issues	None required	Not applicable	None identified
GP7	Relevant Executive Directors have been allocated with delegated responsibility for all actions relating to 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	The Board receives reports x 2 per year on the Board Assurance/ Corporate Risk Register
RF2	None identified	Board assurance sources are identified via CRR process
RF3	None identified	Assurances are balanced across a range of source and not just predominantly Finance related
RF4	None identified	Governance Strategy updated in December each year. Governance infrastructure last reviewed and updated in ~~July 2017~~ October 2018 Board Goverance Self Assessments in 2013, 2014, 2015 2016,

		2017, ~~and~~ 2018 and 2019. Independent Evaluation carried out in March 2015 and March 2018

4. Board engagement and involvement ALB Name: South Eastern HSC Trust Date: 20 March 2019

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 were training or guidance is required and/or Areas were additional assurance is required
GP1	Approved PPI Scheme by Trust Board (Involving You) Board Minutes	None required	Not applicable	None identified
GP2	Approved PPI Scheme by Trust Board (Involving You) Board Minutes PPI Operational Leads Group PPI Sub Committee Stakeholder engagement evidence is included in Directorate Management Plan DoHAccountability Review Meetings Work with wide range of specific user groups and fora eg, TILLI group for disablility Patient Stories User Satisfaction 2 named users on PPI Sub Committee	None required	Not applicable	None identified
GP3	Stakeholder engagement with Business Planning process – DoHS,HSCB, PHA, LCG and RQIA etc	None required	Not applicable	None identified

	A range of methods was adopted to ensure user and public input into the Corporate Plan 2017-2021. Working with local Councils and MLAs. Service user input is sought in the development of relevant business case/plans/strategic documents eg, MH inpatients rationalisation OBC included a user rep on the project Board			
GP4	Range of methods adopted to ensure user and public input into the Corporate Plan 2017-2021. Working with local Councils and MLAs. Trust internet site has Corporate Plan and PPI strategy available and consultation	None required	Not applicable	None identified
GP5	DoH Pathway for all learning letter and DHSSPS communications SAI reports Lessons Learnt Sub Committee – complaints, incidents, litigation, external inquiries, regulatory and review reports Safety & Quality Committee Minutes	None required	Not applicable	None identified
GP6	All public consultations include a bespoke communication/	None required	Not applicable	None identified

	engagement plan. All reform, TYC and other relevant workstreams included stakeholder engagement. External relationships are maintained on a continual basis with local councils, MLAs, LCG etc and relevant staff represent the Trust on a large number of external groups. EMT take every available opportunity to build and maintain relationships with all key stakeholders			

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	None identified	The Business Plan is widely consulted on both internally and externally
RF2	None identified	The Trust has good relationships with external stakeholders, clients, users, client organisations
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 identified
RF5	None identified	The Board has approved a Complaints Procedure and has delegated the monitoring and learning from complaints to its Lessons Learnt Sub Committee

4. Board engagement and involvement ALB Name: South Eastern HSC Trust Date: 20 March 2019

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 were training or guidance is required and/or Areas were additional assurance is required
GP1	Regional Staff Survey 2015/16 Investors In People EFQM Grievance & Discipliary Procedures Whistle Blowing Procedures Quarterly open staff meeting in each locality area Use of technology – intranet update Newsletter to staff Senior Staff Briefings Consultation Engagements plans in place for all areas of significant service change including pre consultation engagement for eg Staff Side	None required	Not applicable	None identified
GP2	Leadership Conferences Workshops on Business/Corporate plans Leadership walkrounds Senior Staff Briefings Intranet Newsletters Consultation process Specific meetings held with staff to request input into the	None required	Not applicable	None identified

	development of Corporate Plan and Leadership Conferences Each Director responsible for DMP and stakeholder engagement is a requirements			
GP3	Leadership Conferences Workshops on Business/Corporate plans Leadership walkrounds Senior Staff Briefings Intranet Newsletters KSF Appraisal process Consultation Process IiP Communication by EMT/Trust Board SQE programme Patient Story	None required	Not applicable	None identified
GP4	Chairman's Awards Patient Experience Celebrations Social Work Conferences/celebration SQE Programmes Director of Nursing Award Compliments & Suggestions External recognition on news page and at Trust Page	None required	Not applicable	None identified
GP5	Policy on Standards of Business Conduct for Managers Professional Codes of Conduct Working Well Together Policy HR Strategy	None required	Not applicable	None identified

	IiP and EFQM HSC Codes of Conduct for Staff			
GP6	Corporate & Directorate Risk Register Risk Management Strategy, Policies & Procedures	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	Action plans have been developed to address the results of the latest staff survey in 2015/16.
RF2	None identified	There are no unresolved staff issues that are significant
RF3	None identified	There are no significant unresolved quality
RF4	None identified	The turnover of staff is problematic in some areas consistent with regional problem of recruitment and this is addressed. Worforce issues are included in the quarterly workforce reports and are reviewed on a monthly basis at Performance Monitoring meetings
RF5	None identified	Best practice is shared with the Trust via a variety of means eg, sub committees, Lunch and Learn sessions, training and awareness session, on the job training etc. Litigation and Risky Business Newsletters.

4. Board engagement and involvement ALB Name: South Eastern HSC Trust Date: 20 March 2019

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 were training or guidance is required and/or Areas were additional assurance is required
GP1	Board programme of events / quality workabouts with evidence of improvements made Carers Group/s Users Groups Visits to Children's Homes Leadership Walkrounds/action plans Environmental Visits by NEDs/action plans Chairman's Awards Patient Experience Awards Active participation at high-profile events Trust Board meetings	None required	Not applicable	None identified
GP2	Board programme of events / quality workabouts with evidence of improvements made Carers Group/s Users Groups Visits to Children's Homes Leadership Walkrounds/action plans Environmental Visits by NEDs/action plans	None required	Not applicable	None identified

	Chairman's Awards Patient Experience Awards Active participation at high-profile events Trust Board meetings MLA meetings Attendance at Council Meetings			
GP3	Board programme of events / quality workabouts with evidence of improvements made Carers Groiup Users Groups Visits to Children's Homes Leadership Walkrounds/action plans Environmental Visits by NEDs/action plans Chairman's Awards Patient Experience Awards Active participation at high-profile events Trust Board meetings	None required	Not applicable	None identified
GP4	Board programme of events / quality workabouts with evidence of improvements made Carers Group Users Groups Visits to Children's Homes Leadership Walkrounds/action plans Environmental Visits by NEDs/action plans Chairman's Awards	None required	Not applicable	None identified

	Patient Experience Awards Active participation at high-profile events Trust Board meetings			
GP5	Evidence that Board minutes are publicly available (on internet) and summary reports arer provided from the private Board meeetings (Confidential Minutes) Internet Site	None required	Not applicable	None identified
GP6	Board members appraisal and personal development process	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	There are a range of processes in place (see GP1 to GP 6) to raise the profile and visibility of the Board
RF2	None identified	Attendance by Board members at events/meetings that enable them to engage with staff is very good (see GP1 to GP6)

Summary Results **ALB Name: South Eastern HSC Trust** **Date: 20 March 2019**

1.Board composition and commitment		
Area	Self Assessment Rating	Additional Notes
1.1 Board positions and size	Green	
1.2 Balance and calibre of Board members	Green	
1.3 Role of the Board	Green	
1.4 Committees of the Board	Green	
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	Green	

timeliness of information		
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	

5. Board impact case studies		
Area	Self Assessment Rating	Additional Notes
5.1 – Performance failure in the area of quality, resources (Finance, HR, Estates) or Service Delivery .	Prison Healthcare	There was no guidance in the document as to how to RAG rate a case study. SET considered it was not applicable to do this for this section Note – only one case study is mandatory.
5.2 Organisational culture change	Not applicable	
5.3 – Organisational strategy	Not applicable	

Areas where additional training/guidance is required		
Area	Self Assessment Rating	Additional Notes
General Comments	-	

Areas where additional assurance is required		
Area	Self Assessment Rating	Additional Notes

General Comments	The Trust welcomes the adoption of this self assessment tool and considered the completion of it a valuable exercise. We will use this as our primary method of self assessment and assurance in the future.	

6. Board impact case studies

6. Board impact case studies

Overview

This section focuses on the impact that the Board is having on the ALB and considers recent case studies in the following areas:

1.Performance failure in the area of quality, resources (Finance, HR, Estates) or Service Delivery;

2.Organisational culture change; and

3. Organisational strategy.

6. Board impact case studies

6.1 Measuring the impact of the Board using a case study approach

This section focuses on the impact that the Board is having on the ALB, it's clients, including other organisations, patients, carers and the public. The Board is required to submit three brief case studies:

- A recent case study briefly outlining how the Board has responded to a performance failure in the area of quality, resources (Finance, HR, Estates) or service delivery. In putting together the case study, the Board should describe:
- Whether or not the issue was brought to the Board's attention in a timely manner;
- The Board's understanding of the issue and how it came to that understanding;
- The challenge/ scrutiny process around plans to resolve the issue;
- The learning and improvements made to the Board's governance arrangements as a direct result of the issue, in particular how the Board is assured that the failure will not re-occur.

- A recent case study on the Board's role in bringing about a change of culture within the ALB. This case study should clearly identify:
  - The area of focus (e.g. increasing the culture of incident reporting; encouraging innovation; raising quality standards);
  - The reasons why the Board wanted to focus on this area;
  - How the Board was assured that the plan(s) to bring about a change of culture in this area were robust and realistic;
  - Assurances received by the Board that the plan(s) were implemented and delivered the desired change in culture.

- A recent case study that describes how the Board has positively shaped the vision and strategy of the Trust. This should include how the NEDs were involved in particular in shaping the strategy.

Note: Recent refers to any appropriate case study that has occurred within the past 18 months.

6. Board impact case studies ALB Name: South Eastern HSC Trust Date: -20 March 2019

6.1 Case Study 1 – Prison Healthcare

Performance issues in the area of quality, resources (finance, HR, Estates) or Service Delivery	Prison Healthcare
Brief description of issue	Prison Healthcare (PHC) has experienced significant staffing shortages over a considerable time due to recruitment and retention challenges with a significant backlog developed in responses to complaints, SAI reviews, and data access requests which required to be addressed to ensure effective learning from investigations and complaints . PHC is inspected by regulatory bodies • Regulation, Quality and Improvement Authority • Criminal Justice Inspectorate • Her Majesty's Inspectorate of Prisons • and other organisations progress investigations relating to patient care including: • Independent Monitoring Board • International Committee of the Red Cross • Prisoner Ombudsman • N.I Ombudsman Reports are received from these external bodies and it is inevitable, with internal reviews also occurring that Prison Healthcare has a large number of recommendations to be met at any given time. A risk presents (due to demand exceeding capacity) of not addressing all of the recommendations in a timely manner and repeat recommendations being made. A significant number of people in custody engage in self - harming behaviour and this leads to significant numbers of reportable incidents under the regional Serious Adverse Incident (SAI) process. These SAI reviews are scrutinised by a range of external bodies e.g. the Prisoner Ombudsman, Coroner, RQIA, HSCB/PHA ,patients and solicitors therefore these reviews require a significant amount of work to ensure accuracy, identify learning and Implement recommendations.

	All deaths in custody are listed for a Coroner's inquest unless the family requests otherwise. All prison inquests are escalated to hearing by jury. Due to a backlog in coroners hearings, inquests often take place years after the event when staff might not still be in post. The preparation time for an inquest is significant due to the amount of information required to present to the inquest hearing and the family's legal teams. The Trust's SAI investigation therefore requires to be robust. The key priority for the Trust is to maintain routine Prison Healthcare services whilst progressing an action plan to address the backlog of SAI and complaint responses. The trust escalated the risks to SET Trust Board the Department of Health (DoH) and the Health & Social Care Board (HSCB) so that they were aware of the risk and how it is being managed. The Trust provides updated monitoring reports on progress on clearing the backlog of work.
Outline Board's understanding of the issue and how it arrived at this	Prison Healthcare is on the SET's Corporate Risk Register. The risks along with the actions in place to mitigate them are considered by the Governance Assurance Committee (this is chaired by a Trust Non- Executive Director; membership comprises Directors and Non-Executive Directors). This committee reports directly to Trust Board and a report and minutes of meetings are presented at the next subsequent Trust Board meeting. All external Inspection reports are also considered at relevant internal meetings and escalated as required (for eg, Confidential Trust Board meeting). Prison Healthcare senior team presented at a Trust Board workshop to provide overview of current services and provide assurance through service improvement plan. Trust Board members have also supported PPI events within the prison establishments. The Director of Prison Healthcare has discussed the litigation challenges and supported an action plan to reduce backlogs.

Outline the challenge/scrutiny process involved	The Risk Register and databases identify progress against targets. Prison Healthcare is often discussed at the Trust's Executive Management Team (EMT) and the minutes of these meetings are circulated to all Non- Executive Directors who may follow up with the lead Director should there be points for clarification or further information needed. In addition updates have been provided at Trust board meetings. An action plan to address all backlogs for complaints/SAIs/legal letters was devised in 2017, implemented and tracked to address backlogs within two years.
Outline how the issue was resolved	Initially a transformation project was implemented - an on-going piece of work with various strands and continues to be implemented. An additional part-time staff member (management support) was resourced to target complaints backlog . Recommendations were themed and a Quality Improvement Fellow was appointed for PHC to lead QI projects which has led to new ways of working - instrumental in ensuring improvement especially around the committal process etc. Team Leaders and Nursing Sisters have been appointed in the operational management structure.to build sustainable managerial capacity. An Engagement worker was appointed and and this has led to enhanced co-production around revision of the complaints process and other areas in PHC. In 2.5 years each stage of the action plan has been achieved to date and a robust plan is in place to complete the remaining work (policies and ISO procedures)
Summarise the key learning points	In this complex service it has been reassuring that the Trust's EMT and Trust Board recognise and support the prison healthcare management team in managing the risk. This has proved

	extremely supportive to PHC managers in times of heightened risk. Prison healthcare remains on the corporate risk register which is reviewed and monitored by EMT, Governance Assurance Committee on a regular basis, prior to submission to a Trust Board meeting (May & November each year). External investigations and multiple recommendations arising places significant demand and competing priorities on a small senior management team. Additional dedicated resource has been required to address backlog which has been building over past years. The stability of the prison environment is a key factor impacting on prison healthcare and beyond the control of healthcare. Regime stability is required to deliver and maintain routine services. A key learning from the improvement work to address complaints and SAI backlog is the importance of engagement of service users to inform effective response. Regular meetings with key stakeholders including Patient Client Council, NI Ombudsman andnd IMB have been effective in discussing expectations. Project management processes to track implementation of recommendations and completion of complaint responses within target deadline have been essential in evidencing improvement. The support of Non-Executive Directors at PHC events and new initiatives means PHC staff feel there is acknowledgment and appreciation from SET for the work that they do in a challenging environment.
Summarise the key improvements made to the governance arrangements directly as a result of above	In 2017-18:- • 30 detailed SAI review reports were submitted from the 2015-17 backlog and the remaining 2017 SAIs will be addressed by the end of March 2019.

	• The backlog of litigation letters has been addressed • The backlog of complaints responses has been addressed and response times are now largely in line with target response times • A new process for data access requests responses has been implemented • 262 recommendations from external and internal reports have been implemented Governance arrangements have improved by: - • Revised enhanced reporting structures – appointment of Band 7 Team Leaders and Nursing sisters • Designated Quality Improvement Fellow- to lead complex QI projects • Increasing accountability at local level • Co-production with people in custody and staff engagement implemented • Pathways and referral systems clarified • Moving forward there are robust actions and an aspirational plan to maintain contemporaneous management and avoid further backlogs

6. Board impact case studies ALB Name: South Eastern HSC Trust Date: 20 March 2019

6.2 Case Study 2 – Not required

Organisational Culture Change	
Brief description of area of focus	-
Outline reasons/ rationale for why the Board wanted to focus on this area	
Outline how the Board was assured that the plan/ (s) in place were robust and realistic	, -
Outline the assurances received by the Board that the plan/(s) were implemented and delivered the desired changes in culture	“

6.3 Case Study 3 – Not required

Organisational strategy	
Brief description of area of focus	
Outline reasons / rationale for why the Board wanted to focus on this area	
Outline how the Board was assured that the plan/ (s) in place were robust and realistic	
Outline the assurances received by the Board that the plan/(s) were implemented and delivered the desired changes in culture	
Specifically explain how the NEDs were involved	