



Department of
Health
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BOARD GOVERNANCE SELF ASSESSMENT TOOL

**For use by Department of Health
Sponsored Arms Length Bodies**

2019/20

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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 is not judged by 'nothing going wrong'. Even in the best boards and organisations bad things happen and board effectiveness is demonstrated by the appropriateness of the response when difficulties arise.

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

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

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

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

Application of the Board Governance Self-Assessment

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

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

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

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

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

Approval of the self-assessment by ALB Board and sign off by

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

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

Overview



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

1. Board composition and commitment (e.g. Balance of skills, knowledge and experience);
2. Board evaluation, development and learning (e.g. The Board has a development programme in place);
3. Board insight and foresight (e.g. Performance Reporting);
4. Board engagement and involvement (e.g. Communicating priorities and expectations);
5. Board impact case studies (e.g. A case study that describes how the Board has responded to a recent financial issue).

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

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

Step 1

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

Summary of Results template which includes identifying areas where additional training/guidance and/or assurance is required.

Step 2

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

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

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

Step 3

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

Scoring Criteria

The scoring criteria for each section is as follows:

Green if the following applies:

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

Amber/ Green if the following applies:

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

Amber/ Red if the following applies:

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

Red if the following applies:

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

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

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

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

1. Board composition and commitment

1. Board composition and commitment overview

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

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

1. Board composition and commitment

1.1 Board positions and size

Red Flag	Good Practice
<ol style="list-style-type: none">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.	<ol style="list-style-type: none">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 its 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.	<ul style="list-style-type: none">• 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
<ol style="list-style-type: none"> 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. 	<ol style="list-style-type: none"> 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 <i>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.</i> 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.
<p>Examples of evidence that could be submitted to support the Board's RAG rating.</p>	<ul style="list-style-type: none"> • 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
<ol style="list-style-type: none">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.	<ol style="list-style-type: none">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.	<ul style="list-style-type: none">• 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
<ol style="list-style-type: none">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.	<ol style="list-style-type: none">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.	<ul style="list-style-type: none">• Scheme of delegation• TOR• Board minutes• Annual Evaluation Reports

1. Board composition and commitment

1.5 Board member commitment

Red Flag	Good Practice
<ol style="list-style-type: none">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.	<ol style="list-style-type: none">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.	<ul style="list-style-type: none">• 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
<ol style="list-style-type: none"> 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). 	<ol style="list-style-type: none"> 1. A formal Board Governance Self-Assessment has been conducted within the previous 12 months. 2. The Board can clearly identify a number of changes/ improvements in Board and Committee effectiveness as a result of the formal self assessments that have been undertaken. 3. The Board has had an independent evaluation of its effectiveness and the effectiveness of its committees within the last 3 years by a 3rd party that has a good track record in undertaking Board effectiveness evaluations. 4. In undertaking its self assessment, the Board has used an approach that includes various evaluation methods. In particular, the Board has considered the perspective of a representative sample of staff and key external stakeholders (e.g. commissioners, service users and clients) on whether or not they perceive the Board to be effective. 5. The focus of the self assessment included traditional 'hard' (e.g. Board information, governance structure) and 'soft' dimensions of effectiveness. In the case of the latter, the evaluation considered as a minimum: <ul style="list-style-type: none"> • 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.
<p>Examples of evidence that could be submitted to support the Board's RAG rating.</p>	<ul style="list-style-type: none"> • 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
<ol style="list-style-type: none"> 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. 	<ol style="list-style-type: none"> 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: <ul style="list-style-type: none"> • 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.
<p>Examples of evidence that could be submitted to support the Board’s RAG rating.</p>	<ul style="list-style-type: none"> • 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
<ol style="list-style-type: none"> 1. Board members have not attended the “On Board” training course within 3 months of appointment. 2. There are no documented arrangements for chairing Board and committee meetings if the Chair is unavailable. 3. There are no documented arrangements for the organisation to be represented at a senior level at Board meetings if the CE is unavailable. 4. NED appointment terms are not sufficiently staggered. 	<ol style="list-style-type: none"> 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.
<p>Examples of evidence that could be submitted to support the Board’s RAG rating.</p>	<ul style="list-style-type: none"> • Succession plans • Induction programmes • Standing Order

2. Board evaluation, development and learning

2.4 Board member appraisal and personal development

Red Flag	Good Practice
<ol style="list-style-type: none"> 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. 	<ol style="list-style-type: none"> 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.
<p>Examples of evidence that could be submitted to support the Board's RAG rating.</p>	<ul style="list-style-type: none"> • 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
<ol style="list-style-type: none"> 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. 	<ol style="list-style-type: none"> 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: <ul style="list-style-type: none"> • performance of the ALB against a range of performance measures including quality, performance, activity and finance and enables links to be made; • Variances from plan are clearly highlighted and explained ; • Key trends and findings are outlined and commented on ; • Future performance is projected and associated risks and mitigating measures; • Key quality information is triangulated (e.g. complaints, standards, Dept targets, serious adverse incidents, limited audit assurance) so that Board members can accurately describe where problematic services lines are ;Benchmarking of performance to comparable organisations is included where possible. 3. The Board receives a brief verbal update on key issues arising from each Committee meeting from the relevant Chair. This is supported by a written summary of key items discussed by the Committee and decisions made. 4. The Board regularly discusses the key risks facing the ALB and the plans in place to manage or mitigate them. 5. An action log is taken at Board meetings. Accountable individuals and challenging/demanding timelines are assigned. Progress against actions is actively monitored. Slips in timelines are clearly identifiable through the action log and individuals are held to account.
<p>Examples of evidence that could be submitted to support the Board's RAG rating.</p>	<ul style="list-style-type: none"> • 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
<ol style="list-style-type: none">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).	<ol style="list-style-type: none">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.	<ul style="list-style-type: none">• 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
<ol style="list-style-type: none"> 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. 	<ol style="list-style-type: none"> 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).
<p>Examples of evidence that could be submitted to support the Board's RAG rating.</p>	<ul style="list-style-type: none"> • 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
<ol style="list-style-type: none"> 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 	<ol style="list-style-type: none"> 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,

	<p>including how that information was collected and quality assured, and any limitations that this may impose.</p> <p>10. Any documentation being presented complies with Departmental guidance, where appropriate e.g. business cases, implementation plans.</p>
<p>Examples of evidence that could be submitted to support the Board's RAG rating.</p>	<ul style="list-style-type: none"> • 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
<ol style="list-style-type: none"> 1. The Board does not receive assurance on the management of risks facing the ALB. 2. The Board has not identified its assurance requirements, or receives assurance from a limited number of sources. 3. Assurance provided to the Board is not balanced across the portfolio of risk, with a predominant focus on financial risk or areas that have historically been problematic. 4. The Board has not reviewed the ALB's governance arrangements regularly. 	<ol style="list-style-type: none"> 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.
<p>Examples of evidence that could be submitted to support the Board's RAG rating.</p>	<ul style="list-style-type: none"> • 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
<ol style="list-style-type: none"> 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 	<ol style="list-style-type: none"> 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.

<p>outcomes of complaints.</p>	<p>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</p> <p>6. The ALB has constructive and effective relationships with its key stakeholders.</p>
<p>Examples of evidence that could be submitted to support the Board's RAG rating.</p>	<ul style="list-style-type: none"> • PPI Consultation Scheme • Complaints • Customer Survey • Regulatory and Review reports

4. Board engagement and involvement

4.2 Internal stakeholders

Red Flag	Good Practice
<ol style="list-style-type: none"> 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. 	<ol style="list-style-type: none"> 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.	<ul style="list-style-type: none"> • 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
<ol style="list-style-type: none"> 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). 	<ol style="list-style-type: none"> 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.
<p>Examples of evidence that could be submitted to support the Board's RAG rating.</p>	<ul style="list-style-type: none"> • 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.....Western Health & Social Care Trust

Date of Board Meeting at which Submission was discussed.....6th August 2020.....(Date)

Approved by(ALB Chair)

1. Board composition and commitment

ALB Name.....WH SCT.....Date.....June 2020.....

1.1 Board positions and size

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas where training or guidance is required and/or Areas where additional assurance is required
GP1	Standing Orders & Scheme of Reservation & Delegation (1a) SFIs (1b) HSS Trusts (Membership Procedures) Regulations NI 1996 (2) Establishment Order 1996 (3) Minutes of Chairman / CE Accountability Meeting with Permanent Secretary (4) Biographical Information on Trust Board Members (5)	Review and update Standing Orders and Standing Financial Instructions	Internal Audit Board Effectiveness Audit identified the Standing Orders and SFIs are out of date and need to be updated.	N/A
GP2	Standing Orders & Scheme of Reservation & Delegation (1a) SFIs (1b) HSS Trusts (Membership Procedures) Regulations NI 1996 (2) Establishment Order 1996 (3) Management Statement / Financial Memorandum (6) Trust Board Minutes (7)	Review and update Standing Orders and Standing Financial Instructions	As above.	N/A
GP3	Standing Orders & Scheme of Reservation & Delegation (1a) SFIs (1b) HSS Trusts (Membership Procedures) Regulations NI 1996 (2)	Review and update Standing Orders and Standing Financial Instructions	As above.	N/A
GP4	Standing Orders & Scheme of	Review and update Standing Orders	As above.	N/A

	Reservation & Delegation (1a) SFIs (1b) HSS Trusts (Membership Procedures) Regulations NI 1996 (2) Establishment Order 1996 (3) Minute of Remuneration and Terms of Service Committee (8) Audit Committee Minutes (27) Governance Committee Minutes / Agenda (9)	and Standing Financial Instructions		
GP5	Letters of Appointment of NEDs by DHSSPS (10)	N/A	N/A	N/A

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	N/A	
RF2	N/A	
RF3	N/A	

1. Board composition and commitment

ALB Name.....WHSCT.....Date..June 2020.....

1.2 Balance and calibre of Board members

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas where training or guidance is required and/or Areas where additional assurance is required
GP1	Performance Plan for CE (12) Biographical Information on Trust Board Members (5) Allocation of NEDs to Various Trust Committees / Directorate Governance Groups (13)	N/A	N/A	N/A
GP2	Biographical Information on Trust Board Members (5)	N/A	N/A	N/A
GP3	Public Authority Statutory Equality and Good Relations Duties Annual Progress Report 2018-2019 (109)	N/A	N/A	N/A
GP4	Biographical Information on Trust Board Members (5)	N/A	N/A	N/A
GP5	Biographical Information on Trust Board Members (5)	N/A	N/A	N/A
GP6	Trust Board Minutes (7)	N/A	N/A	N/A
GP7	Trust Board Minutes (7) Letters of Appointment of NEDs by DHSSPS (10)	N/A	N/A	N/A
GP8	Biographical Information on Trust Board Members (Chairman) (5)	N/A	N/A	N/A
GP9	Biographical Information on Trust Board Members (Chairman) (5)	N/A	N/A	N/A
GP10	Biographical Information on Trust Board Members (5)	N/A	N/A	N/A

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	N/A	
RF2	N/A	
RF3	N/A	
RF4	N/A	
RF5	N/A	
RF6	N/A	

1. Board composition and commitment

ALB Name.....WH SCT.....Date.....June 2020..

1.3 Role of the Board

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas where training or guidance is required and/or Areas where additional assurance is required
GP1	Induction Programme (15) Terms of Reference for Remuneration, Endowment & Gifts, Audit, Governance, Finance & Performance and People Committees (16) Code of Conduct & Accountability (17) Management / Financial Statement (6)	N/A	N/A	N/A
GP2	Code of Conduct & Accountability (17) NED Induction (70) Management / Financial Statement (6)	N/A	N/A	N/A
GP3	Code of Conduct & Accountability (17) Management / Financial Statement (6)	N/A	N/A	N/A
GP4	Code of Conduct & Accountability (17) Management / Financial Statement (6)	N/A	N/A	N/A
GP5	Establishment Order 1996 (3) Letters of Appointment of NEDs by DHSSPS (10) Trust Board Minutes (7)	N/A	N/A	N/A
GP6	Minutes of Chairman / CE Accountability Meeting with	N/A	N/A	N/A

	Permanent Secretary (4)			
GP7	Trust Board Minutes (7) Monthly Financial Performance Report (19) Monthly Performance Management Report (20) Minutes of Chairman / CE Accountability Meeting with Permanent Secretary (4)	N/A	N/A	N/A
GP8	Trust Board Minutes (7)	N/A	N/A	N/A
GP9	Trust Board Minutes (7)	N/A	N/A	N/A
GP10	Trust Board Minutes (7) Confidential Board Minute (7)	N/A	N/A	N/A
GP11	Trust Board Minutes (7)	N/A	N/A	N/A
GP12	Trust Board Minutes (7)	N/A	N/A	N/A
GP13	Trust Board Minutes (7)	N/A	N/A	N/A
GP14	Trust Board Minutes (7)	N/A	N/A	N/A
GP15	Trust Board Minutes (7)	N/A	N/A	N/A
GP16	Schedule of Delegated Authority (21) Trust Board Minutes (7)	N/A	N/A	N/A
GP17	Post Project Evaluation (22)	N/A	N/A	N/A

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	N/A	
RF2	N/A	

RF3	N/A	
RF4	N/A	
RF5	N/A	
RF6	N/A	

1. Board composition and commitment

ALB Name.....WHSCT.....Date...June 2020.....

1.4 Committees of the Board

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas where training or guidance is required and/or Areas where additional assurance is required
GP1	TOR for Committees of Trust Board (16) Revised Governance Structure (23a) Trust Board Minutes (7) Schedule of Delegated Authority (21)	Schedule regular meetings of Improvement through Involvement Committee	Although a number of workshops were held throughout the year, the Terms of Reference for the Improvement through Involvement Committee only agreed by Trust Board on 5th March 2020.	N/A
GP2	TOR for Committees of Trust Board (16) Revised Governance Structure (23a) Trust Board Minutes (7) Schedule of Delegated Authority (21)	Chairman to review revised Governance structure to consider if is working effectively. Possible independent review by Internal Audit during 2021/22.	It was agreed that the revised governance arrangements would be reviewed after 1 year.	N/A
GP3	Schedule of Delegated Authority (21)	N/A	N/A	N/A
GP4	TOR for Committees of Trust Board (16) Revised Governance Structure (23a) Briefing Paper on Governance Arrangements (23b) Reporting Arrangements for Sub-Committee Working Groups (23b) Governance Review TOR (23d) Trust Board Minutes (7) Schedule of Delegated Authority (21)	N/A	N/A	N/A
GP5	TOR for Committees of Trust	N/A	N/A	N/A

	<p>Board (16) Revised Governance Structure (23a) Briefing Paper on Governance Arrangements (23b) Reporting Arrangements for Sub-Committees / Working Groups (23c) Trust Board Minutes (7) Schedule of Delegated Authority (21)</p>			
GP6	<p>Trust Board Minutes (Evidence that Minutes of the reporting Committees to Trust Board have been brought to Trust Board for formal approval) (7)</p>	<p>Improvement through Involvement Committee to provide regular reports to Trust Board</p>	<p>Improvement through Involvement Committee established in place of Patient/Client Experience Group. Improvement through Involvement Committee terms of reference agreed in March 2020 with plans to formally meet 2020/21 year.</p>	N/A
GP7	<p>Annual Reports considered at Trust Board (11) Audit Committee Self-Assessment Checklist (14) Internal Audit Risk Management / Assurance Audit (26) Governance Statement / Mid-Year Statement (35) Governance Committee Minutes (annual review of Governance Structure) (9)</p>	N/A	N/A	N/A
GP8	<p>Trust Board Minutes (7) Briefing Paper on Governance Arrangements (23b)</p>	N/A	N/A	N/A

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	N/A	
RF2	N/A	
RF3	N/A	
RF4	N/A	
RF5	N/A	

1. Board composition and commitment

ALB Name.....WHSCT.....Date....June 2020.....

1.5 Board member commitment

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas where training or guidance is required and/or Areas where additional assurance is required
GP1	Trust Board Attendance Records (25a) Trust Committee Attendance Records (25b)	N/A	N/A	N/A
GP2	Governance Statement / Mid-Year Statement (35)	N/A	N/A	N/A
GP3	Trust Board Minute re Code of Conduct (7) Trust Board Minute re Code of Good Practice (7)	N/A	N/A	N/A
GP4	Annual Schedule of Trust Board and Committee Meetings (30)	N/A	N/A	N/A

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	N/A	
RF2	N/A	
RF3	N/A	
RF4	N/A	

2. Board evaluation, development and learning ALB Name...WHSCT.....Date.....June 2020.....

2.1 Effective Board level evaluation

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas where training or guidance is required and/or Areas where additional assurance is required
GP1	Self Assessment 2018/19	N/A	N/A	N/A
GP2	Self Assessment 2018/19	N/A	N/A	N/A
GP3	Internal Audit of Board Effectiveness 2019/20 (31)	N/A	N/A	N/A
GP4	Staff Surveys (32) Patient / Client Experience Reports (33) Internal Audit of Board Effectiveness 2019/20 (31) Leadership Walkrounds (28)	N/A	N/A	N/A
GP5	Internal Audit of Board Effectiveness 2019/20 (31)	N/A	N/A	N/A

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	N/A	
RF2	N/A	
RF3	N/A	
RF4	N/A	

2. Board evaluation, development and learning ALB Name.....WHSCT.....Date...June 2020.....

2.2 Whole Board development programme

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas where training or guidance is required and/or Areas where additional assurance is required
GP1	NED Induction (70) NED Induction pack including slides and list of documents (70a) Finance Committee and Endowments and Gifts Committee: Induction / Background Paper (70c) Corporate Risk Register Workshop (106a) Clarification re Trust Board Workshops (106b) Delivering Value Trust Board Workshop Agenda (46c)	N/A	N/A	N/A
GP2	Code of Conduct & Accountability (17) Board Assurance Framework (18) Management Statement / Financial Memorandum (6) NED Induction (70) Finance Committee and Endowments & Gifts Committee: NED Induction / Background Paper (70c)	N/A	N/A	N/A
GP3	Statement of Internal Control (35) Governance Committee Minutes (9) Corporate Risk Register	N/A	N/A	N/A

	Workshop (106a)			
GP4	Revised Governance Committee TOR (16a) Revised Governance Structure (23a) Briefing Paper on Governance Arrangements (23b) Governance Review TOR (23d)	N/A	N/A	N/A
GP5	Clarification re Trust Board Workshops (106b)	N/A	N/A	N/A
GP6	NED Induction (70) Board Effectiveness Survey (105) Acumen Programme (82) Corporate Risk Register Workshop (106a) Leadership Walkround Update (107)	N/A	N/A	N/A

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	N/A	
RF2	N/A	

2. Board evaluation, development and learning ALB Name.....WHSCTDate.....June 2020.....

2.3 Board induction, succession and contingency planning

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas where training or guidance is required and/or Areas where additional assurance is required
GP1	NED Induction (70)	N/A	N/A	N/A
GP2	NED Induction (70)	N/A	N/A	N/A
GP3	NED Induction pack including slides and list of documents (70a) Confirmation of induction for newly appointed NEDs (70b) Finance Committee and Endowments and Gifts Committee: Induction / Background Paper (70c) Confirmation from newly appointed NED that induction is sufficient (70d)	N/A	N/A	N/A
GP4	Standing Orders & Scheme of Reservation & Delegation (1a) SFIs (1b) Documented arrangements for CE to be represented at Board Meetings if not available (34)	Update Standing Orders and Scheme of Reservation and Delegation to include arrangements for the CE to be represented at Board Meetings if not available – link with Section 1.1 above	Internal Audit Board Effectiveness Audit identified the Standing Orders and SFIs are out of date and need to be updated.	N/A
GP5	Succession Planning Guidance (37)	N/A	N/A	N/A

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	N/A	N/A
RF2	N/A	N/A
RF3	Update Standing Orders and Scheme of Reservation and Delegation to include arrangements for the CE to be represented at Board Meetings if not available – link with Section 1.1 above	Standing orders (SOs) were last reviewed in 2017 and the Standing Financial Instructions (SFIs) were last reviewed in June 2015. These should be reviewed, updated and approved by Trust Board. Future review dates should be set in these documents and adhered to.
RF4	N/A	N/A

2. Board evaluation, development and learning ALB Name.....WHSCT.....Date....June 2020.....

2.4 Board member appraisal and personal development

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas where training or guidance is required and/or Areas where additional assurance is required
GP1	Annual Performance Appraisal takes place for all NEDs and Directors (29)	N/A	N/A	N/A
GP2	CE Appraisal Form (12) Remuneration Committee Minutes shared with Trust Board (7)	N/A	N/A	N/A
GP3	Chairman's Annual Appraisal (38)	N/A	N/A	N/A
GP4	Objectives set for Directors by CE (39) Objectives set for CE by Chairman (12) Senior Executive Annual Performance Review (see Remuneration Committee TOR) (16)	N/A	N/A	N/A
GP5	Performance Management Objectives for Executive Directors and CE (8 & 12) Example of NED attendance at external seminar (personal development) (41)	N/A	N/A	N/A
GP6	Trust Board Minutes (7)	N/A	N/A	N/A
GP7	Evidence of CPD (42)	N/A	N/A	N/A

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	N/A	
RF2	N/A	
RF3	N/A	
RF4	N/A	

3. Board insight and foresight

ALB Name.....WHSCOT.....Date...June 2020.....

3.1 Board performance reporting

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas where training or guidance is required and/or Areas where additional assurance is required
GP1	Monthly Performance Management Report (20) Quarterly Quality Report (43) Monthly Financial Performance Report (19) Trust Board Minutes (7)	N/A	N/A	N/A
GP2	Monthly Performance Management Report (20) Quarterly Quality Report (43) Monthly Financial Performance Report (19) Risk Management Dashboard (24) Nursing KPI Report (53) Trust Board Minutes (7) Health Checks (111)	N/A	N/A	N/A
GP3	Trust Board Minutes (7) Clinical & Social Care Governance Sub-Committee Briefing Note (75a) Corporate Governance Sub-Committee Briefing Note (75b) Quality & Standards Sub-Committee Briefing Note (88) Governance Committee Minutes / Agenda (9)	N/A	N/A	N/A
GP4	Board Assurance Framework / Corporate Risk Register (18) Governance Committee	N/A	N/A	N/A

	Minutes (9) Trust Board Minutes (7) Corporate Risk Register Workshop (106)			
GP5	Trust Board Action Log (40)	N/A	N/A	N/A

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	N/A	
RF2	N/A	
RF3	N/A	
RF4	N/A	
RF5	N/A	

3. Board insight and foresight

ALB Name.....WHSCT.....Date...June 2020.....

3.2 Efficiency and Productivity

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas where training or guidance is required and/or Areas where additional assurance is required
GP1	Monthly Performance Management Report (20) Trust Board Minutes (7) Trust Delivery Plan / Financial Strategy (44) Governance Committee Minutes re Corporate Risk Register / Board Assurance (9) Mid-Year Accountability Review Minutes (4) Corporate Risk Register / Board Assurance Framework (18)	N/A	N/A	N/A
GP2	Trust Board Minute (7)	N/A	N/A	N/A
GP3	Reform Plan (46a) Trust Delivery Plan / Financial Strategy (44) Briefing Note to Finance & Performance Committee (45) Trust Board Agenda re Finance & Performance Committee (72) Monthly Financial Performance Report (19) Trust Board Update on Transformation (46b) Delivering Value Trust Board Workshop Agenda (46c)	N/A	N/A	N/A
GP4	Post Project Evaluation –	N/A	N/A	N/A

	sample (22) Corporate Risk Register Workshop (106a)			
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Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	N/A	
RF2	N/A	
RF3	N/A	
RF4	N/A	

3. Board insight and foresight

ALB Name.....WHSCT.....Date...June 2020.....

3.3 Environmental and strategic focus

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas where training or guidance is required and/or Areas where additional assurance is required
GP1	CE Reports (47) Corporate Risk Register / Board Assurance Framework (18) Trust Board Minutes (7) Health Checks (111)	N/A	N/A	N/A
GP2	Governance Committee Minutes (9) SAI Learning Reports (48) External Review Dashboard (49) Corporate Parenting Report (50) Trust Board Minutes (7)	N/A	N/A	N/A
GP3	Trust Board Minute (7) Corporate Plan 2019-21 (110)	N/A	N/A	N/A
GP4	Reform Plan (46a) Trust Board Agenda re Finance & Performance Committee (72) Briefing Note to Finance & Performance Committee (45)	N/A	N/A	N/A
GP5	Corporate Risk Register / Board Assurance Framework (18) Trust Board Minutes (7)	N/A	N/A	N/A

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	N/A	
RF2	N/A	
RF3	N/A	

3. Board insight and foresight

ALB Name....WHSCT.....Date....June 2020.....

3.4 Quality of Board papers and timeliness of information

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas where training or guidance is required and/or Areas where additional assurance is required
GP1	Schedule of Board and Committee Meetings (30) Accounts Timetable Circular HSC(F) 05-2020	N/A	N/A	N/A
GP2	Schedule of Board and Committee Meetings (30) Declaration of Interests (54)	N/A	N/A	N/A
GP3	Trust Board Agenda (56)	N/A	N/A	N/A
GP4	Monthly Performance Management Report (20) Monthly Financial Performance Report (19) Quarterly Quality Report (43)	N/A	N/A	N/A
GP5	Example of Business Case Brought to Trust Board (57)	N/A	N/A	N/A
GP6	Internal Audit Programme (102)	N/A	N/A	N/A
GP7	Monthly Performance Management Report (20) Trust Board Minutes (7)	N/A	N/A	N/A
GP8	Trust Board Minutes (7)	N/A	N/A	N/A
GP9	Trust Board Minutes (challenge function of NEDs) (7)	N/A	N/A	N/A
GP10	Example of Business Case Brought to Trust Board (57)	N/A	N/A	N/A

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	N/A	
RF2	N/A	
RF3	N/A	
RF4	N/A	
RF5	N/A	

3. Board insight and foresight

ALB Name.....WH SCT.....Date...June 2020.....

3.5 Assurance and risk management

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas where training or guidance is required and/or Areas where additional assurance is required
GP1	Risk Management Policy (59) Corporate Risk Register (18) Directorate Risk Register (81)	N/A	N/A	N/A
GP2	Corporate Risk Register / Board Assurance Framework (18) Rapid Review Group Briefing Note (59a) Rapid Review Group TOR (59b) Revised Governance Structure (23a) Briefing Paper on Governance Arrangements (23b) Governance Review TOR (23d)	N/A	N/A	N/A
GP3	Board Assurance Framework (18)	Implement recommendations from the Review of Governance Arrangements commissioned by the Trust in February 2020	Purpose of Review is to test if the Trust has a robust integrated governance structure and arrangements in place which offers assurance on patient/client safety and facilitates learning for improvement.	N/A
GP4	Engagement & Experience/Improvement through Involvement Committee (98) Revised Governance Structure (23a) Review of Whistle Blowing Arrangements (104)	N/A	N/A	N/A

	Briefing Paper on Governance Arrangements (23b)			
GP5	Risk Management Policy (59) Incident Reporting Policy (61) Annual Quality Report (62) Board Self-Assessment Action Plan 2019/20 (101) Internal Audit of Clinical & Social Care Governance (103)	N/A	N/A	N/A
GP6	Job Descriptions of Executive Directors (63)	N/A	N/A	N/A

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	N/A	
RF2	N/A	
RF3	N/A	
RF4	N/A	

4. Board engagement and involvement

ALB Name....WHSCT.....Date.....June 2020.....

4.1 External stakeholders

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas where training or guidance is required and/or Areas where additional assurance is required
GP1	PPI Consultation Scheme (64) PPI Strategy (65)	N/A	N/A	N/A
GP2	PPI Consultation Scheme (64) PPI Strategy (65) PPI Survey (66a) PPI Forum (66b) PPI SIG TOR (99a) Patient / Client Experience Reports (33) Equality Scheme (67) Trust Board Minutes (7) Governance Committee Minutes (9) Corporate Themes (92) What Matters to You Day (108) Pathfinder Report (76)	N/A	N/A	N/A
GP3	Trust Delivery Plan / Financial Strategy (44) PPI Strategy (65) MLA Meetings (68) Consultation Document Sample (36)	N/A	N/A	N/A
GP4	Digital Communication Strategy (69) Trust Board Minutes (7)	N/A	N/A	N/A
GP5	SAI Learning Report (48) Share to Learn Magazine (71)	N/A	N/A	N/A
GP6	PPI Strategy (65) Complaints Annual Report (73)	N/A	N/A	N/A

	Patient / Client Experience Reports (33) Mid-Year Accountability Review Minutes (4) MLA Meetings (68) Joint Forum Minutes (74) PPI Forum (66b) PPI SIG TOR (99a)			
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Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	N/A	
RF2	N/A	
RF3	N/A	
RF4	N/A	
RF5	N/A	

4. Board engagement and involvement

ALB Name.....WHSCOT.....Date.....June 2020.....

4.2 Internal stakeholders

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas where training or guidance is required and/or Areas where additional assurance is required
GP1	Staff Survey (32) Whistle Blowing Policy (77) Share to Learn Magazine (71) NOW Newsletter (78) Lesson of the Week (60) Senior Staff Briefings (79) Time out with CMT (58) Pathfinder Report (76)	N/A	N/A	N/A
GP2	Staff Engagement Events – Delivering Value Programme (80) Trust Delivery Plan / Financial Strategy (44) Joint Forum (74) Staff Survey (32)	N/A	N/A	N/A
GP3	Risk Register (include corporate objectives) (81) Staff Induction (corporate objectives) (15)	N/A	N/A	N/A
GP4	Staff Recognition Awards (83) Quality Improvement Showcase Event (84) Dragons Den Competition (85) Junior Doctor Audit Competition (86) NOW Newsletter (78) Annual Quality Report (62)	N/A	N/A	N/A
GP5	Grievance Procedure (87) Whistle Blowing Policy (77)	N/A	N/A	N/A

	Disciplinary Procedure (89) Job Description Sample (90) Induction Programme (15) Code of Conduct (17)			
GP6	Emergency Preparedness & Response Annual Report (93) Fire Training (94) Trust Major Incident Plan (95) Trust Communication (96) Health & Safety Committee (97) Joint Forum Minutes (74) Share to Learn Magazine (71) Risk Register (81/18) Risk Management Policy (59) Directorate Quarterly Quality & Safety Reports (52) Lesson of the Week (60)	N/A	N/A	N/A

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	N/A	
RF2	N/A	
RF3	N/A	
RF4	N/A	
RF5	N/A	

4. Board engagement and involvement

ALB Name.....WHSCT.....Date....June 2020.....

4.3 Board profile and visibility

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas where training or guidance is required and/or Areas where additional assurance is required
GP1	Leadership Walkrounds (28) Staff Recognition Awards (83) QI Showcase Event (84) Dragons Den (85) Trust Board Minutes (7)	N/A	N/A	N/A
GP2	MLA Meetings (68) Engagement & Experience Committee (98) PPI Engagement Events (99)	N/A	N/A	N/A
GP3	MLA Meetings (68) Staff Recognition Awards (83) Attendance at High Profile Event (91)	N/A	N/A	N/A
GP4	PPI Engagement Events (99) Leadership Walkrounds (28) Engagement & Experience Committee (98) Staff Recognition Awards (83) Public Facing Event (51) Trust Board Minutes (Chairman's Business) (7)	N/A	N/A	N/A
GP5	Press Releases (100) Trust Board Minutes – available on intranet (7) NOW Staff Newsletter (78)	N/A	N/A	N/A
GP6	Trust Board Minutes (7)	N/A	N/A	N/A

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	N/A	
RF2	N/A	

Summary Results

ALB Name.....WHSCT..... Date...June 2020.....

1.Board composition and commitment		
Area	Self Assessment Rating	Additional Notes
1.1 Board positions and size	Amber/Green	
1.2 Balance and calibre of Board members	Green	
1.3 Role of the Board	Green	
1.4 Committees of the Board	Amber/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	Amber/Green	
2.4 Board member appraisal and personal development	Green	

3.Board insight and foresight		
Area	Self Assessment Rating	Additional Notes
3.1 Board performance reporting	Green	
3.2 Efficiency and Productivity	Green	
3.3 Environmental and strategic focus	Green	
3.4 Quality of Board papers and timeliness of information	Green	
3.5 Assurance and risk management	Amber/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	Green	
5.2		
5.3		

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

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

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 a recent case study in one of 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 one of three brief case studies:

1. 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.

2. 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.

3. A recent case study that describes how the Board has positively shaped the vision and strategy of the ALB. 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 Western Health & Social Care Trust Date June 2020

6.1 Case Study 1

Performance issues in the area of quality, resources (finance, HR, Estates) or Service Delivery	Title: Industrial Action – November 2019 to January 2020
Brief description of issue	<p>The Trades Unions informed the Trust that they had a dispute about pay and safe staffing levels. A significant portion of the Trust’s staff were members of these Trades Unions. Following ballots members voted for action short of strike and strike action.</p> <p>Given the potential extent and scope of the action when there were already existing pressures in the system as well as additional pressures associated with the winter months, there was recognised risk to the Trust in terms of its ability to provide safe and effective services.</p>
Outline Board’s understanding of the issue and how it arrived at this	<p>Trust Board members were advised at their meeting on 7th November 2019 of four major Trades Unions’ intention to ballot their members on action short of strike and strike action. There was an expectation that other Trades Unions would follow this course of action. Board minutes record that this was an unprecedented action for one of the major Trades Unions which had significant membership within the Trust. Board members acknowledged that staff have the right to take Industrial Action and that they did not take this course of action lightly.</p> <p>The Chief Executive and Directors provided Board members with updates at each meeting and addressed questions on how the industrial action was being managed, the challenges faced, the impact on the provision of care to patients/clients/service users and monitoring arrangements put in place. Information to increase understanding provided to Board members included:</p> <ul style="list-style-type: none"> • Ongoing collaborative working relationships between Directorate representatives, Human Resources and Trades Unions representatives to ensure the safe provision of essential services • Co-ordination of activities in the lead up to and during any period of industrial action short of strike and strike action • Minimising the impact to those most in need of services including red flag patients or those judged to be clinically urgent

	<ul style="list-style-type: none"> • Mitigating risks to patient and client safety during the Industrial Action for example by cancelling and re arranging access to services • Escalation of issues to one of the Bronze* Control Rooms and/or to central Sliver Control as required • Monitoring of the reporting of incidents, SAls and complaints to identify any emerging safety issues throughout the period. • An extraordinary Trust Board meeting was held on 26th November for Trust Board to consider and approve the addition of this risk to the Corporate Risk Register and consider the controls and assurances. • Review and update of the Trust’s Corporate Risk Register to reflect the risk.
Outline the challenge/scrutiny process involved	<ul style="list-style-type: none"> • Planning for and response to the Industrial Action by a significant number and range of staff groups whilst maintaining safe services over an extended period • Limited time to re-arrange services as Trades Unions were only required to provide a minimum of 7 days’ notice of any industrial action • Securing derogations with Trades Unions in order to provide safe staffing levels for activities that were unable to be downturned or re-arranged • Securing derogations with Trades Unions for support infrastructure where necessary e.g. for continuation of some mandatory training • Minimising the impact to those most in need of services including red flag patients or those judged to be clinically urgent • Mitigating risks to patient/client/service user safety during the Industrial Action for example by cancelling and rearranging access to services at the earliest opportunity • Rescheduling cancelled appointments as quickly as possible although dates, times and extent of further periods of Industrial Action were not known • Communicating to clients and service users changes to their appointments and keeping the public updated • Emergency preparedness arrangements in relation to transporting blood components for emergency theatres • Cyber security monitoring • Growing implications of the action short of strike as staff ‘work to rule’ and withdraw from overtime • Absence of Ministers at Stormont to address concerns associated with the Industrial Action as officials at Department of Health had reached the limits of authority and affordability.

<p>Outline how the issue was resolved</p>	<p>Using the emergency planning Silver and Bronze arrangements, with full representation across all directorates, and partnership arrangements with the Trades Unions throughout the process aided by the parallel Trades Unions Control Rooms in operation enabled immediate safety issues to be escalated and derogations obtained.</p> <p>Trust Management were involved in regional discussion with the Department of Health through Silver Command arrangements throughout the dispute to provide local influence during the dispute with the Trades Unions.</p> <p>The Minister for Health confirmed the details of a proposed resolution of the Agenda for Change (AfC) dispute which included restoration of pay parity with England with effect from 1 April 2019 to be maintained in 2020/21 and a new pay structure will be put in place from 1 April 2021. The Minister also proposed arrangements to secure safe staffing in relation to nursing and midwifery, social work and social care staff and the delivering care policy directive. Members from 3 of the major Trade Unions voted to accept the proposals.</p>
<p>Summarise the key learning points</p>	<ul style="list-style-type: none"> • Ongoing partnership and collaboration between Directorate representatives, Human Resources and Trades Unions representatives • Provision of information to staff via Trust Communication/social media/line management and representatives of Trades Unions • Function and role of Bronze Control Rooms. In particular, cross directorate working within Bronze ensured a whole systems approach to assess the Trust-wide impact and mitigate immediately. • Recording and monitoring of derogation requests and communication of the outcome to managers and affected staff • Emergency key roles e.g. Emergency Planner • Accuracy of information required and provided • Reduction in services to match available staffing on strike days • Plan to mitigate risks as staff changed their minds at short notice in relation to participation in the industrial action • Importance of consistent Assistant Directors within Bronze Control Rooms who were able to make and action decisions quickly throughout their Directorates. • Representative Assistant Directors from each Directorate in Bronze Control Rooms was essential to support decision making and be able to communicate back to their heads of

	service/managers.
Summarise the key improvements made to the governance arrangements directly as a result of above	<ul style="list-style-type: none"> • In departments where skills shortages were noted during Industrial Action additional training has been provided to build resilience and reduce dependency on key employees/teams such as Switchboard and Porterage. • Business Continuity Plans reviewed and updated. • Development of Trust Industrial Action Guides for Managers and Staff, which are available for any Industrial Action the Trust may encounter in future. • Greater understanding across the organisation of the roles and cross-boundary working and their contribution to the flow of patients through the hospital and community. • Learning from Bronze and Silver has allowed quick stand up of arrangements during the COVID pandemic.

6. Board impact case studies

ALB Name.....Date.....

6.2 Case Study 2

Organisational Culture Change	Title:
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. Board impact case studies

ALB Name.....Date.....

6.3 Case Study 3

Organisational strategy	Title:
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	