Governance Statement 2016/17

Recommendations:

The NHS Board is asked to:
1. consider and note the attached Statement of Assurance by the Audit Committee; and
2. approve the attached Governance Statement (which is part of the Annual Report and Accounts 2016/17) for signature by the Chief Executive.

Purpose of Paper

As Accountable Officers, Chief Executives of NHS Boards have responsibility for maintaining a sound system of internal control within their organisations. Chief Executives of NHS Bodies, as Accountable Officers, are required to sign the Governance Statement as part of the annual accounts. The statement describes the effectiveness of the organisation’s governance processes and system of internal control; it is not restricted to internal financial controls and considers all aspects of the organisation’s system of internal control and corporate governance, clinical governance, staff governance and risk management. If any significant aspect of governance or internal control is found to be unsatisfactory, this should be disclosed in the Governance Statement.

Guidance issued by the Scottish Government states that NHS Boards are responsible for reviewing the effectiveness of internal control having regard to the assurances obtained from the Audit Committee and any other standing committee which covers internal control e.g. risk management and clinical governance committees. The remit of the NHS Greater Glasgow and Clyde Audit and Risk Committee incorporates this responsibility; it states that: “The Audit and Risk Committee will provide the NHS Board and the Accountable Officer with an annual report on the NHS Board’s system of internal control timed to support finalisation of the Statement of Accounts and the Statement on Internal Control. This report will include a summary of the Committee’s conclusions from the work it has carried out during the year.” This is attached as Appendix 1.

The format of the Governance Statement and its contents are specified in guidance issued by the Scottish Government. The statement for 2016/17 has been prepared in accordance with this guidance. The statement is attached as Appendix 2

Key Issues to be considered

At its meeting on 20 June 2017, the Audit Committee reviewed the system of internal control and based on this review, approved the following documents, with a recommendation that the
Board Official

Chief Executive should sign the Governance Statement:

1. The Statement of Assurance from the Audit Committee to the NHS Board on the system of internal control within NHS Greater Glasgow and Clyde (attached as Appendix 1);

2. NHS Greater Glasgow and Clyde Governance Statement (this forms part of the Annual Report and Accounts – NHS Board Paper 17/23 – but for ease of reference, a copy is also attached here at Appendix 2).

**Any Patient Safety /Patient Experience Issues**
None

**Any Financial Implications from this Paper**
None

**Any Staffing Implications from this Paper**
None

**Any Equality Implications from this Paper**
None

**Any Health Inequalities Implications from this Paper**
None

**Has a Risk Assessment been carried out for this issue? If yes, please detail the outcome.**
None

**Highlight the Corporate Plan priorities to which your paper relates**
Improving quality, efficiency and effectiveness

**Author**   Financial Governance Manager

**Tel No**    0141 201 4737

**Date**    June 2017
Statement of Assurance by the Audit and Risk Committee in respect of the system of internal control within NHS Greater Glasgow and Clyde for 2016/17

As Accountable Officer, the Chief Executive is required to sign a Governance Statement as part of the annual accounts. The Governance Statement is required to describe the effectiveness of the system of internal control and to declare any significant aspects where this system is unsatisfactory.

In accordance with its remit and the Scottish Government Audit and Risk Committee Handbook, the Audit and Risk Committee reviews all audit reports on systems of internal control within NHS Greater Glasgow and Clyde. The result of this review is reported in this Statement of Assurance to the NHS Board and is intended to inform the Governance Statement.

The Audit and Risk Committee's review of the system of internal control in place during 2016/17 was informed by a number of sources of assurance including the following:

1. All matters considered by the Audit and Risk Committee;
2. Review of the NHS Board's internal control arrangements against the extant guidance from the Scottish Government Health Directorates;
3. Statements of assurance by executive directors;
4. Reports issued by the internal auditors, including the annual statement of their independent opinion on the adequacy and effectiveness of the system of internal control;
5. Reports issued by Audit Scotland arising from the audit of the annual accounts and the programme of performance audits;
6. Statement of Accounts;
7. Third party assurances in respect of key services provided by National Services Scotland and NHS Ayrshire and Arran;
8. Annual Fraud Report 2016/17;

Conclusion

The Internal Auditor's Annual Report gives the opinion that controls are:

"Generally satisfactory with some improvements required. Governance, risk management and control in relation to business critical areas is generally satisfactory. However, there are some areas of weakness and non-compliance in the framework of governance, risk management and control which potentially put the achievement of objectives at risk. Some improvements are required in those areas to enhance the adequacy and effectiveness of the framework of governance risk management and control."

Three of the audit reviews undertaken during 2016/17 were rated overall as high risk. These were Waiting Times Management and Reporting, Business Continuity Management and Reporting and Monitoring Arrangements for Efficiency Savings, all of which were known areas of challenge for the NHS Board. Internal Audit acknowledged that management had
accepted the findings in these reviews and that action plans were in place to address issues identified.

The Audit and Risk Committee considers that these matters should be disclosed in the Chief Executive's Governance Statement.

On the basis of our review, it is the opinion of the Audit and Risk Committee that, overall, there was a satisfactory system of internal control in place within NHS Greater Glasgow and Clyde throughout 2016/17.

The Audit and Risk Committee recommends, therefore, that subject to the inclusion of the above matters, the NHS Board should approve the Governance Statement and that the Governance Statement should be signed by the Chief Executive as Accountable Officer.

Allan Macleod
Chair, Audit and Risk Committee
20 June 2017
Governance Statement

Scope of Responsibility

As Accountable Officer, I am responsible for maintaining an adequate and effective system of internal control that supports compliance with the organisation’s policies and promotes achievement of the organisation’s aims and objectives, including those set by Scottish Ministers. Also, I am responsible for safeguarding the public funds and assets assigned to NHSGGC. I have been supported in my role as Accountable Officer throughout the year by a multi-disciplinary management team, focused on ensuring the delivery of strategic objectives in a prudent, economical, efficient and effective manner.

Purpose of Internal Control

The system of internal control is based on an ongoing process designed to identify, prioritise and manage the principal risks facing the organisation. The system aims to evaluate the nature and extent of risks, and manage risks efficiently, effectively and economically.

The system of internal control is designed to manage rather than eliminate the risk of failure to achieve the organisation’s aims and objectives. As such, it can only provide reasonable and not absolute assurance.

The process within the organisation accords with guidance from Scottish Ministers in the Scottish Public Finance Manual (SPFM) and supplementary NHS guidance, and has been in place for the financial year and up to the date of approval of the annual report and accounts.

The SPFM is issued by Scottish Ministers to provide guidance to the Scottish Government and other relevant bodies on the proper handling and reporting of public funds. The SPFM sets out the relevant statutory, parliamentary and administrative requirements, emphasises the need for efficiency, effectiveness and economy, and promotes good practice and high standards of propriety.

NHS Endowments

In accordance with IAS 27 – Consolidated and Separate Financial Statements, the Financial Statements consolidate the NHSGGC Endowment Funds. This statement includes any relevant disclosure in respect of these Endowment Accounts.

IJB Accounts

In accordance with IFRS 11 – Joint Arrangements, the Financial Statements consolidate the IJB Accounts of Glasgow, Inverclyde, Renfrewshire, East Dunbartonshire, East Renfrewshire and West Dunbartonshire. This statement includes any relevant disclosure in respect of these IJB Accounts.

Governance Framework

Under the terms of the Scottish Health Plan, the Board is a board of governance. Its purpose is to ensure the efficient, effective and accountable governance of the local NHS system and to provide strategic leadership and direction for the system as a whole, focusing on agreed outcomes. During the year from 1 April 2016 to 31 March 2017, the Board met on six occasions.
At 31 March 2017 the Board comprised the Chair, twenty-six non-executive and five executive board members; of the non-executive members, seven are Council Members nominated by their respective councils. In advance of the Scottish Council Elections on 4 May 2017, the terms of office the Councillors serving on the board of NHSGGC ended on 30 April 2017. The new Councils have formed their new administrations and made nominations to the Board.

Board members are appointed by Scottish Ministers and are selected on the basis of their stakeholder position or the particular expertise which enables them to contribute to the decision making process at a strategic level.

The Board and its Standing Committees have clearly defined and documented roles and responsibilities, and the purpose of each committee is set out below. The non-executive members of the Standing Committees have the opportunity to scrutinise and challenge the Board’s executive management.

The Board has an integrated approach to governance across clinical areas, performance management, staff and involving and engaging people in its services and developments. These are defined through the standing committees outlined below. These committees are charged with assessing performance of the Board and regularly receive relevant performance data for each of their respective areas. The Board itself receives at each meeting an Integrated Performance Report, which outlines performance over a period of time, with relevant actions to improve where relevant – presented by the responsible Director.

Examples include performance around cancer waiting times, where improvement actions have been presented (Cancer Plan) and discussed by the Director of Regional Services.

The Board, therefore, has the following standing committees to support it, and which are directly accountable to it:

- Acute Services Committee;
- Area Clinical Forum;
- Audit and Risk Committee;
- Clinical and Care Governance Committee;
- Endowments Management Committee (a committee of the Endowment Trustees);
- Finance and Planning Committee;
- Pharmacy Practices Committee;
- Public Health Committee; and
- Staff Governance Committee (including Remuneration Sub-committee).

**Acute Services Committee**

The scope of the Acute Services Committee shall encompass the functions of scrutiny, governance and strategic direction for Acute Services; covering the functions below:

- The quality function of services delivered to patients;
- Effective patient safety and governance systems;
- Delivery of Corporate Objectives, including those set out in the Local Development Plan as agreed with Scottish Government Health and Social Care Directorates;
- Financial Planning and Management;
• Staff and patient focused public involvement; and
• Ensuring that learning from performance issues drives improvement.

The areas of clinical governance, patient safety, quality and finance have been integrated in reporting terms and there is a focus on organisational change and capability for improvement.

The Acute Services Committee met six times during the year. Members of the committee during the year were Mr R Finnie (Chair, from 1 July 2016), Mr I Lee (Chair, until 30 June 2016), Ms S Brimelow, Ms M Brown, Dr H Cameron, Mr S Carr, Cllr G Casey, Cllr J Clocherty, Professor Dame Anna Dominiczak, Mr I Fraser, Cllr M Kerr, Cllr A Lafferty, Dr D Lyons, Mr A Macleod, Ms D McErlean, Cllr McIlwee, Ms R Micklem, Ms A-M Monaghan, Cllr M O’Donnell, Mr I Ritchie and Mr D Sime.

In addition to the members of the Committee, meetings were attended by other Board members, directors, chief officers and senior managers.

Area Clinical Forum

The role of the Area Clinical Forum is to represent the multi-professional view of the advisory structures for medical, dental, nursing and midwifery, pharmaceutical, optometric, professionals allied to medicine, healthcare scientists, psychology and community health partnerships to NHSGGC ensuring the involvement of all the professions across the local NHS system in the decision-making process.

NHSGGC has six fully functioning statutory Professional Advisory Committees. Their relationships with IJBs and how they provide advice will be reviewed. The statutorily established Professional Advisory Committees (some of which have sub-committee structures) are:

• Area Medical Committee;
• Area Nursing and Midwifery Committee;
• Area Dental Committee;
• Area Pharmaceutical Committee;
• Area Allied Health Professions and Healthcare Scientists Committee; and
• Area Optometric Committee.

Membership of the Area Clinical Forum comprises the Chair and Vice-Chair of each Professional Advisory Committee. The Area Clinical Forum also includes as members the Chair and Vice Chair of the Area Psychology Committee. The forum met six times during 2016/17, and was chaired by Dr H Cameron.

Audit and Risk Committee

The purpose of the Audit and Risk Committee is to assist the Board and the Accountable Officer deliver their responsibilities for the conduct of business, including the stewardship of funds under their control. In particular, the Committee seeks to provide assurance to the Board and the Accountable Officer that an appropriate system of internal control had been in place throughout the year. The Audit and Risk Committee met four times during 2016/17, and its members were Mr A Macleod (Chair), Mr S Carr, Mr R Finnie, Ms J Forbes, Dr D Lyons,
Ms D McErlean, Ms A-M Monaghan, Cllr M O'Donnell, Dr R Reid, and Mr D Sime. In fulfilling its remit, the Audit and Risk Committee was supported by the Audit and Risk Committee Executive Group, which met four times during the year.

Clinical and Care Governance Committee

Arising from a desire to strengthen Non-executive oversight of clinical governance arrangements across NHSGGC, the Board established the Clinical Care and Governance Committee in June 2016. Its functions are to:

- ensure clinical care and services provided by NHSGGC, including those provided in partnership with other organisations, is of an appropriate quality;
- ensure the clinical and care governance arrangements are effective, including interactions with other organisational arrangements, in improving and monitoring the quality of clinical care;
- provide assurance to the Board that NHSGGC is meeting its statutory and mandatory obligations relating to the NHS Duty of Quality; and
- provide advice and assurance to the Board that clinical service proposals are consistent with the continued provision of safe and effective care.

The committee met twice during 2016/17, and its members were Ms S Brimelow (Chair), Dr H Cameron, Mr A Cowan, Professor Dame Anna Dominiczak, Mr I Fraser, Cllr G Casey, Dr D Lyons, Ms D McErlean, Cllr M O'Donnell and Mr I Ritchie.

Endowments Management Committee

Responsibility for Board's Endowment Funds lies with the Trustees, who are all members of the Board. The Trustees have delegated to the Endowments Management Committee the role of reviewing proposals and making recommendations to the Trustees with respect to policies on expenditure and donations, investment strategy and any other matters that may assist the Trustees in discharging their duties.

The committee receives regular reports from the investment managers, and reviews the performance of the portfolio against relevant benchmarks and investment objectives. It also reviews reports on fund income and expenditure and the list of all the funds under stewardship. During the year to 31st March 2017, the membership of the Endowments Management Committee comprised Dr R Reid, Mr S Carr, Cllr M Devlin, Mr R Finnie, Ms J Forbes, Cllr A Lafferty, Mr I Lee, Mr A MacLeod, Cllr M MacMillan, Ms D McErlean, Cllr M O'Donnell, Mr I Ritchie, Rev Dr N Shanks, Mr D Sime and Mr M White. The committee met three times during the year and was chaired by Dr Reid.

Finance and Planning Committee (FPC)

Previously, there was no single forum for Board members to have an oversight of the process of financial and strategic planning and for the Board to collectively influence how IJBs develop in terms of strategic and financial planning. The Finance and Planning Committee was, therefore, established by the Board in June 2016.

The remit of the FPC comprises three core elements:

- Finance and Planning;
The committee considers the Board’s Strategic and Integrated Business Planning activities, ensuring that strategic planning objectives are aligned with the Board’s overall objectives, strategic vision and direction. It also ensures that the Property & Asset Management Strategy is aligned with the Clinical Strategy, and is supported by affordable and deliverable Business Cases and reviews overall development of major schemes including capital investment business cases.

The members of the FPC were Mr J Brown (Chair), Ms S Brimelow, Ms M Brown, Mr S Carr, Professor Dame Anna Dominiczak, Mr R Finnie, Ms J Forbes, Mr I Fraser, Cllr M Kerr, Dr D Lyons, Mr A MacLeod, Mr J Matthews, Ms T McAuley, Cllr M Macmillan, Ms D McErlean and Ms R Sweeney. The committee met three times during 2016/17.

Pharmacy Practices Committee

The role of the Committee is to carry out the functions of NHSGGC in terms of the National Health Service (Pharmaceutical Services) (Scotland) Regulations 2009 (as amended), i.e. to prepare “the pharmaceutical list” – the list of those eligible to provide pharmaceutical services within the Board area.

The Committee is also empowered by NHSGGC, to exercise other functions as delegated to it under the National Health Service (Pharmaceutical Services) (Scotland) Regulations 2009 (as amended) to the extent that those functions are not delegated to an officer of the Board under the Scheme of Delegation. Board members who sat on the Pharmacy Practices Committee were Mr R Finnie, Ms S Brimelow Mr A Cowan and Mr I Fraser. In addition there are four professional advisers and three lay members. The committee met on seven occasions during 2016/17.

Public Health Committee

At its meeting in December 2016, the Board agreed the establishment of the Public Health Committee. Its remit is to promote public health and oversee population health activities and to develop a long term vision and strategy for public health.

The membership of the committee during 2016/17 was Mr J Matthews (Chair), Ms M Brown, Mr A Cowan, Mr J Legg and Dr D Lyons. In addition there are eight professional advisors who are members of the committee. Whilst being constituted during 2016/17, the first meeting of the committee was not held until April 2017.

Staff Governance Committee

The purpose of the Staff Governance Committee is to provide assurance to the Board that NHSGGC meets its obligations in relation to staff governance under the National Health Service Reform (Scotland) Act 2004 and the Staff Governance Standard. The Staff Governance Committee is a Committee of the Board. In particular, the Committee will seek to ensure that staff governance mechanisms are in place that take responsibility for performance against the Staff Governance Standard and are accountable for progress towards achievement of the Standard.
During 2016-17 the committee met on four occasions and was jointly chaired by Mr D Sime (until September 2016), Ms D McErlean (from October 2016) and Ms M Brown. The other members were Cllr M Devlin, Mrs J Donnelly, Cllr A Lafferty, Mr J Legg, Cllr M Macmillan, Mrs T McAuley, Cllr J McIlwee, Cllr M O'Donnell and Rev Dr N Shanks.

The Staff Governance Committee also has a sub-committee which is responsible for the application and implementation of fair and equitable systems for pay and for performance management. The main role of the Remuneration Sub-committee is to ensure the application and implementation of fair and equitable systems for pay and for performance management on behalf of the Board as determined by Scottish Ministers and the Scottish Government Health and Social Care Directorates.

Whilst pay arrangements for NHS staff are determined under national arrangements, the pay arrangements for the Board’s senior managers whose posts are part of the Executive and Senior Management Cohorts are, subject to Scottish Government Health and Social Care Directorates guidance. The Remuneration Sub-committee met twice during 2016/17, and, in accordance with Scottish Government Health and Social Care Directorates guidance, it determined and reviewed the pay arrangements for the Board’s senior managers whose posts are part of the Executive and Senior Management Cohorts, and ensured that a fair, equitable and effective system of performance management for these groups was in operation.

Clinical Governance

The Clinical and Care Governance Committee (and prior to that, the Acute Services Committee) monitors clinical governance arrangements and developments. The Chair of the Committee and the Medical Director, as designated Executive Lead for Clinical Governance, have joint responsibility for maintaining a sound system that supports the achievement of the aims and objectives of clinical governance. The Board Clinical Governance Forum supports the Executive Lead for Clinical Governance in the discharge of this responsibility.

Financial Governance

The oversight of financial planning and financial monitoring forms part of the role of both the Board and the Acute Services Committee, whilst the Audit and Risk Committee forms a view on the systems of financial control with NHSGGC. In addition, during the year, the Finance and Planning Committee was established. As described above, its role is to monitor three core elements - Finance and Planning, Property and Asset Management and Strategic/Capital Projects.

Information Governance

The last twelve months have continued to see progress in Information Governance.

The Information Commissioner’s Office (ICO) carried out an audit on the Board’s compliance with data protection in May 2016 and reviewed three areas: Governance, Security and Subject Access Requests. A number of recommendations were made with good progress being achieved in progressing these. A follow up audit took place in March 2017 and the ICO was satisfied with our progress and did not require any further audit updates.
Information Governance officers continue to ensure staff are aware of their obligations to protect patient and staff data by continued participation in training programmes, including the Acute Mandatory Training Programme and the Foundation Management Programme.

Two new information governance and IT security policies were introduced and eight policies were reviewed and updated, together with a number of communications delivered to staff.

Other governance arrangements

The conduct and proceedings of the Board are set out in its Standing Orders; the document specifies the matters which are solely reserved for the Board to determine, the matters which are delegated under the Scheme of Delegation and the matters which are remitted to a Standing Committee of the Board.

The Standing Orders also include the Code of Conduct that Board members must comply with, and, along with the Standing Financial Instructions, these documents are the focus of the Board’s Annual Review of Governance Arrangements. The annual review also covers the remits of the Board’s Standing Committees.

In addition to the Code of Conduct for Members, the Board has in place a Code of Conduct for Staff. This includes reference to the disclosure internally or externally by staff who have concerns about patient safety, malpractice, misconduct, wrongdoing or serious risk. There is also in place a well-established complaints system, whereby members of the public can make a formal complaint to the Board regarding care or treatment provided by or through the NHS, or how services in their local area are organised if this has affected care or treatment; information on our complaints procedures is available on the NHSGGC website.

All of the Board’s executive directors undertake a review of their development needs as part of the annual performance management and development process. A leadership development framework is in place to offer a range of development activities to meet needs identified, with additional support from the Human Resources department when required. Access to external and national programmes in line with their development plans and career objectives is also available. During the year, board members completed a diagnostic self assessment tool-kit, to measure the Board’s efficiency. The Chief Executive is accountable to the Board through the Chair of the Board. The Remuneration Sub-committee agrees the Chief Executive’s annual objectives in line with the Board’s strategic and corporate plans.

Non-executive directors have a supported orientation and induction to the organisation as well as a series of in depth development sessions identified during the year. Opportunities for development also exist, at a national level, for some specific non-executive roles such as Chairman and Area Clinical Forum Chairs.

To ensure that the Board complies with relevant legislation, regulations, guidance and policies, the Corporate Planning, Policy and Performance Team produces a monthly policy update which highlights recent publications and developments in health policy. This includes information regarding Scottish Government consultations and legislation, reports from "think tanks" and health policy organisations and UK wide developments. Internal policies are created in line with the Board’s Policy Development Framework, which ensures that there is a consistent and clear approach to policy development, consultation, approval, dissemination/communication, access to documents and review, and that NHSGGC complies with relevant legislation, governance, audit and controls assurance requirements. All policies,
strategies or procedures are reviewed every three years as a minimum, or sooner if there is a specific legislative or service requirement or change in guidance, law or practice.

NHSGGC has a whistleblowing policy in place. The Board is committed to achieving the highest possible standards of service and the highest possible ethical standards in public life in all of its practices. To achieve these ends, it encourages staff to use internal mechanisms for reporting any malpractice or illegal acts or omissions by its staff. The Board wishes to create a working environment which encourages staff to contribute their views on all aspects of patient care and patient services. All staff have a duty to protect the reputation of the service they work within. The Board does not tolerate any harassment or victimisation of staff using this Policy, and treats this as a serious disciplinary offence, which will be dealt with under the Board’s Disciplinary Policy and Procedure.

NHSGGC strives to consult with all of its key stakeholders. We do this in a variety of ways. How we inform, engage and consult with patients and the public in transforming hospitals and services is an important part of how we plan for the future. To fulfill our responsibilities for public involvement, we routinely communicate with, and involve, the people and communities we serve, to inform them about our plans and performance.

Public Partnership Forums provide a mechanism for promoting the routine involvement of local people in the design and delivery of the health services they use. This process of involvement is required before we can decide to begin consultation on a proposed service change.

We held our formal Annual Review where we were held to account in public in respect of our performance against targets.

We also strive to engage with staff; we have well established methods of communication (Staff Newsletter, Core Briefs and Team Briefs), and also the “Facing the Future Together” initiative which allows greater engagement with staff, and encourages more staff to be involved in contributing to decision making in the areas in which they work.

NHSGGC is committed to working in partnership with its staff, other public sector agencies and voluntary sector bodies. There are regular meetings of the Area Partnership Forum (APF). The Board, in conjunction with the HSCPs, has well developed community planning processes to enable it to work effectively with local authorities and the voluntary sector to implement a whole system approach to providing patient care. This work is reported to, and monitored by, the Board through the HSCP committee structure.

Review of Adequacy and Effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control and the quality of data used throughout the organisation. My review is informed by:

- the executive directors and managers within the organisation who have responsibility for developing, implementing and maintaining internal controls across their areas;
- the work of the internal auditors, who submit to the organisation’s Audit and Risk Committee regular reports which include their independent and objective opinion on the adequacy and effectiveness of the organisation’s systems of internal control together with recommendations for improvement; and
• comments made by the external auditors in their management letters and other reports.

The following processes have been applied in maintaining and reviewing the effectiveness of the system of internal control:-

• The Board, along with its Standing Committees, met regularly during 2016/17 to consider its plans and strategic direction, to allocate resources, to review the management of performance and to receive minutes and reports from its Standing Committees.

• Within the Acute Division, the Chief Officer (Acute) chairs monthly meetings of the Operational Management Group and the Strategic Management Group. Service directors, Medical, Nurse, Finance, Planning and HR Directors attend the two groups. The whole system Directors meetings are held quarterly chaired by the Chief Executive and in attendance are the IJB Chief Officers, Acute division representatives and other Directors comprising Finance, Medical, Nursing, Public Health, Planning, HR, HI&T. In addition the Board Corporate Directors meet regularly. This is chaired by the Chief Executive and is attended by the Chief Officer Acute Services and the Corporate Directors, with a focus on developing and aligning the financial and strategic planning processes, at which all Directors and Chief Officers come together as a whole system, are held quarterly.

• The Audit and Risk Committee provides assurance that an appropriate system of internal control is in place. The Committee met throughout the year, reviewing the system of internal control.

• The Internal Auditors delivered their service based on an approved risk-based audit plan and is compliant with Public Sector Internal Audit Standards.

• The External Auditors also considered the adequacy of the processes put in place by the Chief Executive as Accountable Officer, as well as providing external assurance on the work of Internal Audit in 2016/17.

• Work has continued during the year to achieve the targets set out in the Local Delivery Plan. Reporting mechanisms have been further developed to ensure a culture of continuous improvement continues to be promoted.

• Staff objectives and development plans include where appropriate maintenance and review of internal controls.

• A performance on-line appraisal system is in place for senior staff with personal objectives and development plans designed to support the Board in the attainment of corporate objectives. Other staff are performance assessed under the Knowledge and Skills Framework.

• An on-line Register of Staff Interests system is maintained. It ensures effective management control of the information held on the staff register of interests and identifies potential conflicts of interest.

• In accordance with the principles of best value, the board aims to foster a culture of continuous improvement. The Board’s processes focus strongly on best value and is committed to ensuring that resources are used efficiently, effectively and economically, taking into consideration equal opportunities and sustainable development requirements.
Risk Assessment

NHSGGC has a Risk Management Strategy in place. It describes how we aim to provide high quality and safe services to the public it serves, in an environment which is safe for the staff it employs or contracts with, to provide services.

In fulfilling this aim, NHSGGC has established a robust and effective framework for the management of risk. The framework will be proactive in identifying and understanding risk, build upon existing good practice and integral to strategic and service planning, decision making, performance reporting and health care service delivery. The strategy is based on the belief that Risk Management is:

- a key activity to ensure the health and well-being of patients, visitors and staff;
- an inclusive and an integral part of our health care services and set against guiding risk management principles;
- implemented with good practice acknowledged and built upon; and
- a major corporate responsibility requiring strong leadership commitment and regular review.

We believe that the provision of high standards of health, safety and welfare within a risk management framework is fundamental to the provision of high standards of health care. The following principles underpin our approach to risk management in NHSGGC:

- A consistent and standard approach to risk management;
- Integral to strategic and service planning and informs performance review;
- Involvement of clinicians and key stakeholders to support effective prioritisation and to inform decision-making;
- Comprehensive and systematically integrated into all processes;
- Responsibility for management, escalation, monitoring and communication of key risks is clearly defined;
- Risk is managed at the operational level closest to the risk supported by clear escalation processes;
- All types of risks are considered including NHSGGC’s strategic risks; and
- Provides assurance that effective systems are in place to manage risks.

All of the key areas within the organisation maintain a risk register; the high level risks that the Board needs to ensure are being managed are then consolidated into the Corporate Risk Register. The Corporate Risk Register summarises the main risks identified within each of the organisational areas, and the processes by which these risks are being managed, and is presented to the Audit and Risk Committee for approval on a six monthly basis. No new significant risks were identified during the year.

Notwithstanding there is a strong application of risk management practices across the Board, particularly in clinical services, the Board is constantly reviewing Risk Management processes, under the guidance of the Risk Management Steering Group. Within the year, this review has also taken cognisance of comments at the Audit and Risk Committee, and in a review by the Board’s Internal Auditors.
The areas identified for improvement relate to the structure and content of the Corporate Risk Register, the resources allocated to the management of the Corporate Risk Register, and the Datix roll-out programme.

Executive management are currently drafting a term of reference to engage external support to:

- ‘Build on the current use of risk registers by rolling-out further across the organisation the electronic risk register module Datix (including training);
- Ensure the RMSG has a more active role in ensuring a coherent and high quality description of risks and the associated controls; and
- To ensure the underlying risk management processes are more capably reflected in the Corporate Risk Register.

As recorded in the Corporate Risk Register, the following are the highest rated risks together with the recorded mitigation actions:

<table>
<thead>
<tr>
<th>Risk</th>
<th>Mitigating Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Board faces an unprecedented financial challenge in 2017/18, with an overall savings challenge within the main Board of £97.8m. Savings have been identified, but there remains a significant gap. In addition the savings identified contain significant risk and many are due to crystallise later in the financial year.</td>
<td>The Board are continuing to work to; Identify additional savings schemes (both locally and nationally). Bring savings schemes forward into the earlier part of the financial year. Focus on the delivery of currently identified schemes and reduce the risk rating. Identify additional sources of income and balance sheet management. Manage our capital allocation to ensure an optimal out-turn for the Board. Identify options and propositions to negotiate the budget settlement with IJBs.</td>
</tr>
<tr>
<td>The use of non-recurring funds and reserves and the underachievement of savings throughout 2015-16 and 2016-17 has created a significant risk to the sustainability of the Board. Due to the scale of the financial challenge and underlying recurring financial imbalance, a transformational programme will be required to deliver a step change in the size and scale of recurring savings and efficiencies needed in 2017/18 and beyond.</td>
<td>The Board is currently devising a 3-5 year Strategic Plan to ensure a model of affordable service delivery and quality patient care up to, and beyond, 2020. This will draw together all the Board’s existing plans and strategies and also take cognisance of the regional agenda.</td>
</tr>
<tr>
<td>Reduction in Capital funding and pressure</td>
<td>Implementation of Division wide</td>
</tr>
<tr>
<td>Relevance</td>
<td>Response</td>
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<td>--------------------------------------------------------------------------</td>
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<tr>
<td>on revenue resources impacts on backlog maintenance and Health and Safety obligation leading to the possibility of non compliance with applicable Health and Safety legislation and SGHD policies and guidance.</td>
<td>property management approach including assessment of premises compliance with standard consistent methodologies. Regular reports to SMG / OMG on deployment of capital resources and investment priorities. Property asset management strategy in place.</td>
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<tr>
<td>Increased delays in discharging patients from hospital and increased bed days due to pressures on local authority funding.</td>
<td>Regular monitoring of position and mechanisms for dialogue with all local authorities through the Acute Services Division organisational structure and HSCPs. Regular reporting to HSCPs, Acute Strategic Management Group (SMG), directorate management teams and the Board. Regular liaison between the Board Chief Executive, HSCP Chief Officers and local authority Chief Executives. Additional funding allocated to assist in reducing delays in discharging patients.</td>
</tr>
<tr>
<td>Failure to achieve waiting time targets</td>
<td>Compliance with Treatment Time Guarantee - regular reports to be provided to Board Acute Services Committee, Directors Access Group/SMG. Weekly monitoring against milestones and action plans. Continuous cancer tracking and weekly review of cancer tracking reports. Flexible working practice of clinicians. Pooled pan-Glasgow waiting lists. Routine reporting to Acute Division SMG and ASC.</td>
</tr>
<tr>
<td>Managing emergency patient flows; Managing unscheduled care and the impact on downstream bed management.</td>
<td>Regular performance reports to SMG / OMG on a weekly basis; bi-monthly reports to Acute Services Committee (ASC) and the Board. Local Unscheduled care groups looking at performance on a site by site basis.</td>
</tr>
</tbody>
</table>
LEAN methodology adopted on three acute sites to look at specific elements of emergency patient flow.

Board established a Programme Board, undertaking a root and branch review of Unscheduled Care.

The Acute Division fails to achieve the current cost containment measures in place and continue to overspend in-year. This is particularly relevant to the major cost pressure areas around medical locum spend and nurse bank spend.

On-going projects in particular areas such as VAT recovery on locums, provision of a managed locum booking service and an external rostering review.

Regular reporting to the SMG, OMG and ASC.

Actions and accountabilities arising from the Performance Review Groups.

Establishment of the new FPC.

In respect of clinical governance and risk management arrangements we continue to have:

• clearly embedded risk management structures throughout the organisation;
• a strong commitment to clinical effectiveness and quality improvement across the organisation;
• a sound cycle of annual clinical governance reporting arrangements for operational entities with devolved responsibilities; and
• a robust performance management framework that provides the context to support statistics with a high level of qualitative information.

There are training programmes, available to all staff, which include training on risk assessment, hazardous substances, general awareness of safety and display screen equipment risks. Practical training sessions provided by the organisation include a range of moving and handling training for staff primarily involved in patient handling, and also training for staff who may be exposed to violence and aggression. Both moving and handling and violence and aggression training courses are based on a robust training needs analysis and the concept of risk assessment is a fundamental component of the training.

Health and Safety

The Health and Safety Executive (HSE) undertook an inspection programme in February and March 2017, and they submitted a formal report in April 2017. The report has indicated that there will be no Improvement Notices served on NHSGGC. The HSE has, however, indicated that they are serving a Notification of Contravention letter which details a number of statutory breaches related to the areas of inspection. There are also breaches of legislation, but whilst these are not deemed at a level where an Improvement Notice is warranted, they will require significant activity within the Board to resolve. The HSE has indicated that there are breaches related to management of falls, management of sharps and management of skin health. Each of these breaches will require a specific action in order to comply with the relevant legislation. A work plan has been agreed, with leads identified for each contravention, and a short life working group has been established to progress the actions. A
governance group, chaired by the Director of Human Resources and Organisational Development, will also be established to monitor the implementation of the agreed plan.

Integration

The Board has worked in partnership with the six councils to establish agreed principles for financial management including budget management, virement and establishing terms of reference for IJB Audit and Risk Committees. Work has also been carried out to establish governance arrangements, including internal audit, which will give assurance to the Board that each IJB is performing in line with its strategic plan.

Developments

The organisation continues its commitment to a process of ongoing development and improvement: developing systems in response to any relevant reviews and developments in best practice. In particular, in the period covering the year to 31 March 2017 and up to the signing of the accounts the organisation has continued to monitor, review and enhance its governance arrangements to support the organisational structure.

Significant Issues

During the course of their work, the internal auditors identified a number of weaknesses in the Board’s internal control systems.

The internal auditors raised a high risk finding during 2015/16 during their review of business continuity planning arrangements. They carried out follow-up work during 2016/17 and found that while some work has been undertaken by management, none of the four findings in the original report had been fully completed and that there remained action required to address the original actions to improve the Board’s business continuity management. We have now, under the direction of the Director of Public Health, set up a short-life working group to address this matter. A Business Continuity Planning lead for each part of the organisation has now been identified and tasked with identifying the critical services in each of their areas, following which, a newly developed template will be completed for each critical service. This exercise is scheduled to be completed by December 2017.

In December 2016, the internal auditors reported on the Board’s arrangements for waiting times management and reporting. They highlighted that NHSGGC works proactively and has very detailed, timely and granular information which is available to those who make the operational and management decisions to manage waiting and treatment times. However, they identified a weakness, which they rated as high rated risk, in respect of recovery plans which are required to address waiting list issues. The Board has since taken steps to address the report findings; performance is monitored at Board, Acute and Sector/Directorate level through the Board’s performance monitoring framework. The Board and ASC receive detailed Performance reports outlining performance against a range of agreed metrics. Any exceptions to the performance targets are highlighted in a detailed report to ensure all improvement actions are identified and monitored. Sector/Directorate Performance Review Groups (PRG) meet quarterly and identify improvement actions based on exceptions to the performance scorecard. A robust monitoring process is applied to ensure actions are implemented. Following each PRG, an action plan is circulated detailing action required, lead and timescales for implementation. Action plans are reviewed at each subsequent PRG. Acute Division Directors discuss any issues that arise, on a weekly basis.
Reporting and monitoring arrangements of efficiency savings was also identified by the internal auditors as an area of high risk. Their review sought to determine the extent to which the projected savings were managed, monitored and reported throughout the year. Whilst they found that effective monitoring systems were in place with accurate information available on a regular basis to enable key stakeholders to monitor current performance, the level of unplanned savings still to be obtained in the fourth quarter of the 2016/17 financial year was significant. It increased the risk that the outstanding cash releasing efficiency savings (CRES) target of would not be obtained. Without effective and complete plans in place it increased the risk of NHSGGC being unable to meet CRES targets. There was a lack of transparency of the extent of unallocated plans in reporting to the FPC and the Board. The unallocated plans were last reported to the FPC in November. There was a lack of evidence of these unallocated plans being escalated to the Board to drive action. A number of actions were agreed to mitigate the finding. A deadline will be put in place to ensure that all CRES plans fully identify savings removing the need for having unallocated elements within their plans. Monthly financial reporting of progress towards the CRES target at department or service level will headline the total amount of savings for which there are no plans in place (unallocated savings). The level of unallocated savings within the savings plans should be reported to the Deputy and Director of Finance on a monthly basis. The Director of Finance will report to the FPC on the level of unallocated savings still be identified across NHSGGC throughout the financial year, with escalation to the Board as necessary to ensure timely action is taken.

As referred to in the Financial Performance pages we continue to face new pressures and as we enter the new financial year, the need for us to continue to review and change the way we deliver care to patients continues apace. In order to meet our challenging financial targets during the year ahead, we will need to continue to work together to deliver more service re-design and more efficient ways of using our staff and financial resources to deliver services in the most effective way to our patients.

There are elements of our service which are put under considerable strain resulting in significant challenges in meeting key targets, particularly around accident and emergency waiting time targets and treatment time guarantees. Whilst we have struggled to consistently achieve the 95% 4 hour Accident and Emergency target, we have achieved the 18 week RTT target. We continue to focus on meeting all waiting times targets although financial constraints, staffing shortages and increasing demand present an ever difficult landscape.

**Cyber attack**

On Friday the 12th May 2017 there was an International Cyber Attack.

Within the NHSGGC area, eleven GP practices were identified as being impacted. All affected GP Practices were directly connected via the Scottish Wide Area Network (SWAN). There was no infection to any systems within the NHSGGC private network.

During initial awareness of International Cyber Attack the Scottish Government’s eHealth Critical Incident Team were active. The Incident team worked with NHS Scotland Health Boards & Scottish Government to evaluate impact, where necessary invoke pro-active & re-active plans to reduce and mitigate impact to Patient care and eHealth Services.

Clinical services across NHSGGC continued to provide patient care, and there was no loss of any data nor impact to operational services as a result of the downtime.
Disclosures

With the exception of the matters noted above, no other significant control weaknesses or issues have arisen during the year, and no significant failures have arisen in the expected standards for good governance, risk management and control. Therefore, I have no other disclosures to report.