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 2017/18) 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 Governance Statement. 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 2017/18 has been prepared in accordance with this guidance. The statement is attached as Appendix 2.
Key Issues to be considered
At its meeting on 19 June 2018, the Audit and Risk Committee reviewed the system of internal control and based on this review, approved the following documents, with a recommendation that the Chief Executive should sign the Governance Statement:

1. The Statement of Assurance from the Audit and Risk 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 18/33 – 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 2018
Statement of Assurance by the Audit and Risk Committee in respect of the system of internal control within NHS Greater Glasgow and Clyde for 2017-18

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 2017-18 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 2017-18;

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 audit findings identified during 2017-18 were rated as high risk - Achieving Financial Balance, Waiting Times Management and Mental Health: Crisis management. 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 2017-18.

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
19 June 2018
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 on-going 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 2017 to 31 March 2018 the Board met on six occasions.

At 31 March 2018 the Board comprised the Chair, twenty-four non-executive and five executive board members; of the non-executive members six are Council Members nominated by their respective councils.
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.

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

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

The Board undertakes, on an annual basis a review of corporate governance arrangements to ensure that they are fit for purpose.

Acute Services Committee
The scope of the ASC comprises 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 LDP as agreed with SGHSCD;
- Financial Planning and Management (in conjunction with the F&PC);
- 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 ASC met six times during the year. Members of the committee during the year were Mr R Finnie (Chair), Ms S Brimelow, Ms M Brown, Dr H Cameron, Mr S Carr, Cllr J Clocherty, Cllr M Hunter, Mrs T McAuley, Mrs D McErlean, Ms A-M Monaghan, Ms A Thompson and Mr I Ritchie.

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. 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, along with the Chair and Vice-Chair of the Area Psychology Committee. The forum met six times during 2017-18; the first two meetings were chaired by Dr H Cameron, and subsequent meetings were chaired by Ms A Thompson.

Audit and Risk Committee
The purpose of the ARC is to assist the Board and the Accountable Officer in delivering 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 appropriate systems of internal control and risk management had been in place throughout the year. The ARC met on five occasions during 2017-18, and its members were Mr A Macleod (Chair), Mr S Carr, Mr R Finnie, Ms J Forbes, Dr D Lyons, Mr J Matthews, Cllr J McColl, Mrs D McErlean and Ms A-M Monaghan. In fulfilling its remit the ARC was supported by the Audit Committee Executive Group, which met three times during the year.
Clinical and Care Governance Committee
Non-executive oversight of clinical governance arrangements across NHSGGC is provided by the Clinical Care and Governance Committee. 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 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 four times during 2017-18, and its members were Ms S Brimelow (Chair), Dr H Cameron, Mr A Cowan, Professor Dame Anna Dominiczak, Mr I Fraser, Dr D Lyons, Mrs D McErlean, Mr I Ritchie and Ms A Thompson.

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. The Endowment Funds Accounts are audited by BDO.

During the year to 31st March 2018, the membership of the Endowments Management Committee comprised Mr I Ritchie (Chair), Cllr C Bamforth, Mr S Carr, Mr R Finnie, Ms J Forbes, Mr A MacLeod, Cllr J McColl, Mrs D McErlean, Cllr I Nicolson, and Mr M White. The committee met four times during the year.

Finance and Planning Committee
The remit of the Finance and Planning Committee (F&PC) is to oversee the financial and planning strategies of the Board, oversee the Board’s Property and Asset Management and Strategic Capital Projects and provide a forum for discussion of common issues arising from the six Integrated Joint Boards.

The remit of the F&PC comprises the following core elements:
- Finance and Planning;
- Property and Asset Management; and
- Strategic/Capital Projects.

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 F&PC were Mr J Brown (Chair), Ms S Brimelow, Ms M Brown, Mr S Carr, Professor Dame Anna Dominiczak, Ms J Donnelly, Mr R Finnie, Ms J Forbes, Mr I Fraser, Dr D Lyons, Mr A Macleod, Mr J Matthews, Ms T McAuley, Mrs D McErlean and Ms R Sweeney. The committee met five times during 2017-18.

**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 (Chair), Mr A Cowan, and Mr I Fraser. In addition there are four professional advisers and three lay members. The committee met on nine occasions during 2017-18.

**Public Health Committee**

The remit of the Public Health Committee is to promote public health and oversee population health activities and to develop a long term vision and strategy for public health.

Members of the committee during 2017-18 were Mr J Matthews (Chair), Ms M Brown, Mr A Cowan, Mrs J Donnelly, Cllr M Hunter, Mr J Legg and Dr D Lyons. In addition there are eight professional advisors who are members of the committee. The committee met four times during 2017-18.

**Staff Governance Committee (SGC)**

The purpose of the SGC 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 SGC is a Board appointed Committee. 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 2017-18 the committee met on four occasions and was jointly chaired by Mrs D McErlean and Ms M Brown. The other members were Cllr J Clocherty, Mrs J Donnelly, Mr J Legg, Mrs T McAuley, Cllr J McColl, Cllr S Mechan and Ms R Sweeney.

The SGC 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 Committee (RMC) 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 SGHSCD.

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 SGHSCD guidance. The RMC met twice during 2017-18, and, in accordance with SGHSCD 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 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 the NHS Board, the F&PC and the ASC. Regular reports on the Board’s financial position are considered by these groups. The ARC has oversight of, and forms a view on, the systems of financial control with NHSGGC.

Information Governance
During the year, there has been continued progress in Information Governance (IG) with a number of work streams on-going to prepare the Board for the implementation of the new General Data Protection Regulation (GDPR) which came into force in May 2018. The IG Steering Group met on four occasions and continues to monitor IG compliance and receive regular reports on data breaches, security compliance, training and subject access requests. IG officers continue to ensure staff are aware of their obligations to protect patient and staff data by continued participation in training programmes including mandatory training modules. All IG policies have been reviewed to ensure they are compliant with the new legislation. A number of IT security policies have been produced to ensure compliance with the NHSScotland Information Security Framework 2015 and the Cyber Resilience Strategy 2017. A number of communications has been issued to staff to ensure awareness and compliance.

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. There is also an Endowments Charter which governs the administration of the Board’s Endowment Funds.

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 Chair and Area Clinical Forum Chairs.

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. 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 regular reports to the organisation’s ARC. Reports include the auditors’ independent and objective opinion on the adequacy and effectiveness of the organisation’s systems of internal control together with recommendations for improvement; and

- statements 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 six times during 2017-18 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 (OMG) and the Strategic Management Group (SMG). Service directors, Medical, Nurse, Finance, Planning and HR Directors attend the two groups.

- The Chief Executive chairs a monthly meeting of the Corporate Management Team, attended by the HSCP Chief Officers, Acute division Chief Operating Officer and other Directors comprising Finance, Medical, Nursing, Public Health, Human Resources, eHealth, Communications and the Employee Director. The focus of the group includes the development of proposals for the Board on financial and capital allocations and LDP, approval of system-wide policy, ensuring Clinical Strategy/Transformational Plan reflects the population needs, monitoring variations in performance against local and national targets/guarantees, oversight of Board-wide functions including Civil Contingencies, e-Health, Facilities accommodation and property, board-wide service planning and approval of material investments and disinvestment propositions. In addition the Board Corporate Directors meet weekly. This is also chaired by the Chief Executive and is attended by the Chief Officer Acute Services and the Corporate Directors.
The ARC provides assurance that an appropriate system of internal control is in place. The Committee met regularly 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 2017-18.

Work has continued during the year to achieve the targets set out in the LDP. 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. The performance of other staff is 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 (CRR). The CRR 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 ARC for approval on a six monthly basis.

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 (RMSG). During the year, the RMSG has

• reviewed and updated the structure and content of the CRR;
• engaged external support, in the form of a co-opted position on the RMSG;
• rolled-out the electronic risk register module further across the organisation; and
• ensured it has a more active role in ensuring a coherent and high quality description of risks and the associated controls.

The following are the highest risk rated areas recorded in the CRR:

• achievement of elective waiting time targets in respect of: inpatient/outpatient and day case targets/Treatment Time Guarantees (TTG); diagnostic targets; cancer targets; and condition specific targets.
• achievement of unscheduled care targets in respect of: managing emergency patient flows; and managing the impact on downstream bed management.
• increased delays in discharging patients from hospital resulting in increased bed days and deterioration in condition of patients awaiting discharge.
• there is a significant financial challenge in-year, unlikely to be met through CRES. The reduction in funding and the underachievement of savings has required the use of non-recurring funds and reserves to balance, creating an underlying recurring deficit of £68m going into 2018/19.
• inconsistent assessment and application of Child Protection procedures.
• inconsistent assessment and application of Adult Support and Protection procedures.
• emerging pathogens represent a risk because often the epidemiology and routes of transmission are not fully understood. The potential consequence is cross transmission and outbreaks.

Management has implemented a range of control measures to mitigate the effects of each of these risks, and are also working on additional actions which will strengthen controls and further reduce the consequences.
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; these 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 submitted a formal report in April 2017. The HSE issued a Notification of Contravention letter which detailed a number of statutory breaches related to the areas of inspection. The HSE indicated that the breaches related to management of falls, management of sharps and management of skin health. Following subsequent inspection visits to the Queen Elizabeth University Hospital the HSE issued 2 Improvement Notices related to skin health of domestic staff. The notices focused on skin health surveillance procedures and the use of gloves by domestic staff.

A detailed Action Plan has been provided to the HSE within the agreed timescale to ensure that full compliance with both the Notices and the Contraventions is achieved. The HSE were provided with the Action Plan in July 2017 and also an updated version with further supporting documentation, in March 2018. An extension has been granted to the Improvement Notices to allow compliance by September 2018. The organisation is awaiting further communication from the HSE on this matter. The Director of Human Resources and Organisational Development has established a governance group to monitor the implementation of the agreed action plan. Directors are provided with monthly action plan updates on compliance, highlighting areas of non-compliance whereby local action is required.

Integration
The Board has worked in partnership with the six councils, and has agreed principles for financial management including budget management, virement and terms of reference for IJB audit committees. Governance arrangements, which include internal audit, 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 2018 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
The internal auditors highlighted a number of weaknesses that they considered should be reported in this Governance Statement. Through the course of their internal audit work they identified the following three high risk findings:

- Achieving Financial Balance
  *Audit finding* - The internal auditors highlighted that whilst the Board successfully achieved financial balance in the year, this, however, relied heavily on the use of non-recurring support. The percentage of total savings achieved which were on a non-recurring basis was approximately 70% in 2017-18, compared with around 40% in 2015-16. While non-recurring savings will always form part of a Board’s savings, the lack of enduring savings increases future financial challenges and poses a risk to the NHS Board’s financial sustainability. It is critical that the NHS Board puts in place a transformation plan that will deliver recurring savings and provide financially sustainability for the future.
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  *Management response* - The conclusions in this report serve to highlight Executive management’s view of the Board’s financial position. The reports to the Finance and Planning Committee in February, April and June 2018 outline these issues, and the actions being taken to address them. A range of significant actions and measures have been put in place; the FIP, designed to achieve short/medium term recurring financial stability, the Moving Forward Together programme to deliver medium to longer term transformation and the West of Scotland Regional Planning work to transform service delivery across the wider geographical area.

- Waiting times management
  *Audit finding* - The internal auditors reviewed the Board’s arrangements for waiting times management, and reported that, whilst a significant level of time and resource had been expended on implementing the programme of demand and capacity gap assessment and improvement, there was a risk, however, that the exercise would not deliver its key objectives. As such, there was a risk that management’s response to the deteriorating performance against waiting time targets would be insufficient.
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  *Management response* - In order to address the deteriorating performance against the Treatment Time Guarantee, management implemented a programme of demand and capacity gap assessment and improvement. The demand and capacity gap assessment exercise is of significant strategic and clinical importance to NHSGGC and its delivery is both complex and multi-faceted. However, the internal auditors found that the exercise, despite its complexity and scale, has been initiated and partly executed without any formal project management discipline. 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% four 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. It has been agreed that management will revisit the project, and formalise the project management framework supporting the exercise. Specifically management
will document the specific project objectives and planned benefits; define the project phases and sub-phases, outputs from each key milestones and timescales; define success measures for the exercise, and the plan for assessing how far these have been realised; establish, document and communicate roles and responsibilities associated with each phase of the project; establish and document how the project will be monitored; and consider the need to form a working team tasked with overall delivery of the programme.

- Mental Health: Crisis Management
  
  **Audit finding** - The internal auditors performed sample testing over the execution of the three risk assessment tools operating across NHSGGC, and found that in a significant number of instances, across all three tools, risk assessments were not completed in accordance with the governing policies in place.

  **Management response** - In response to the above finding, management prepared a refresher session for all impacted groups of staff to remind them of the policies and procedures in place for each risk assessment tool and the importance of retaining the appropriate evidence. A programme of quality reviews has been implemented across all departments whereby cases are sampled to ensure risk assessment procedures have been followed and evidenced on patient files. Instances of non-compliance should be fed back to individual managers and departments and action plans prepared to address recurring issues. The reporting of the quality assurance programme has been built into the revised governance framework.

**Cyber security**

In May 2017, NHSGGC was affected by 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. There was no infection to any systems within the NHSGGC private network.

During initial awareness of the attack, the Scottish Government’s eHealth Critical Incident Team were active. The Incident team worked with NHS Scotland Health Boards and the Scottish Government to evaluate the impact and, where necessary, invoke both pro-active and re-active plans to reduce and mitigate the 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 was there any impact to operational services as a result of the downtime. Board staff are regularly reminded of the importance of cyber security.

**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.