

Greater Glasgow NHS Board

Board Meeting
15 July 2003

Board Paper No 03/46

Convener of the Audit Committee

6

REVIEW OF SYSTEM OF INTERNAL CONTROL 2002/2003

Recommendation:

Members are asked

- (a) to consider the attached report and to review and evaluate the NHS Board's system of internal control
- (b) to recommend that the Chief Executive signs the Statement of Internal Control subject to the Statement disclosing the matters identified in the review

Background

The review by the Audit Committee intended to provide assurance to the NHS Board that an effective system of internal control is in place and being complied with. It also allows the Chief Executive to sign the Statement of Internal Control which forms part of the NHS Board's annual accounts.

The attached report was considered and agreed by the Audit Committee on 1 July 2003.

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1 INTRODUCTION

- 1.1 Best practice in respect of corporate governance within the private sector has been developed by the introduction of the London Stock Exchange's "Combined Code" of requirements for listed companies and the publication of "Internal Control: Guidance for Directors on the Combined Code". The latter publication is better known as "The Turnbull Report" and examines how the requirements of the "Combined Code" can be implemented. These requirements include the following:
- (a) the Board should maintain a sound system of internal control to safeguard shareholders' investment and the company's assets;
 - (b) the Directors should, at least annually, conduct a review of the effectiveness of the group's system of internal control and should report to shareholders that they have done so. The review should cover all controls, including financial, operational and compliance controls and risk management.
- 1.2 To reflect the developments in the private sector, the Scottish Executive issued HDL (2002) 11 "Corporate Governance: Statement on Internal Control" in March 2002. This required Chief Executives of NHS Bodies as Accountable Officers to sign a Statement of Internal Control (SIC) as part of the annual accounts. The SIC extended beyond financial controls and included risk management and review processes. Bodies must declare in the SIC those areas where control arrangements are not fully in place and where further work is required.
- 1.3 The Scottish Executive issued guidance to accompany HDL (2002) 11. This stated that 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 eg risk management committee or clinical governance committee. The Remit of the NHS Greater Glasgow Audit Committee incorporates this responsibility when it states that it shall be responsible for review of the Board's system of internal control and making recommendations to the Board regarding the SIC.
- 1.4 This report is intended to provide the Audit Committee with evidence of the existence of and compliance with an effective system of internal control during 2002/2003. The Committee is invited to review and evaluate the system of internal control and to report the results to the Board at the meeting on 15 July 2003. The report to the Board should include a recommendation that the Chief Executive should sign the SIC and should indicate which if any weaknesses requires to be disclosed in the SIC (section 2 summarises the main points and offers a suggested recommendation to the NHS Board).
- 1.5 The following sources of evidence are presented for consideration.
- Reports by the External Auditors Section 3
 - Reports by the Internal Auditors Section 4
 - Assessment against Minimum Financial Control Standards Section 5
 - Progress on Risk Management Section 6
 - Annual Review of Corporate Governance Section 7
 - Annual Fraud Report Section 8
 - Property Transactions Monitoring Section 9
 - Clinical Governance Section 10

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2 SUMMARY AND CONCLUSION

- 2.1 Using the evidence presented in this report, Members of the Audit Committee have evaluated the effectiveness of the NHS Board's system of internal control and this report sets out the result of this evaluation.

Based on its review of the available evidence, the Audit Committee concluded that, subject to the 2 exceptions listed below, the system of internal control complies with the required control standards. It is therefore recommended that the Chief Executive signs the Statement on Internal Control and that the Statement should declare the three exceptions listed below.

(a) **Risk Strategy**

The following points should be noted :

- a Risk Management Strategy, and supporting arrangements, were approved by the NHS Board in October 2002
- the Board made a submission for recognition at CNORIS level 1 in November 2002, as agreed
- of the 19 standards an acceptable level was achieved in 18 and one fell short of the required 75% pass mark, namely Standards, Use and Retrieval of Records – a score of 66% was achieved. Under the “fast track” procedures a re-submission was made in April 2003 and CNORIS Level 1 was awarded in May 2003

(b) **Practitioner Services**

From 1 April 1999, the Practitioner Services Division (PSD) of the Common Services Agency (CSA) assumed responsibility for calculating and making payments to Primary Care contractors on behalf of Primary Care Trusts (PCTs). Following this transfer of responsibilities, a number of “critical” deficiencies in the control processes operated by PSD were highlighted by the Service Auditor and External Auditors of PSD and these have been reported annually in the Statement of Internal Control at the Primary Care Trust and the NHS Board.

For the year to 31 March 2003, the External Auditor of the CSA, Audit Scotland, reported on the process of appointing the new Service Auditor and reviewed the scope, work and findings arising from the 2002/2003 Service Audit. Audit Scotland also reported on progress made in implementing recommendations arising from previous Service and External Audits and concluded that:

- the Service is more fully involved with setting the scope of the work of the Service Auditor
- the respective responsibilities of the CSA, PSD and PCTs, with regard to Payment Verification (PV), are more clearly understood
- PV is happening extensively and, with a few exceptions, is in accordance with the protocol contained in the Partnership agreement

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- levels of patient exemption checking have significantly increased
- measures are in place at the CSA to ensure that recommendations made by the Service Auditor are being acted upon and reported in a more timely manner

In 2002/2003, there were no “critical” issues noted by Audit Scotland, however some issues of “high” importance where further improvement is required were identified, as noted below:

- in the area of Information Communication and Technology, there is a need to introduce over-arching PSD-wide standards and policies for areas such as security, user administration and change management
- PV checks in respect of General Pharmaceutical Services have not been fully implemented or reported in a timely manner
- recoveries have been made through the patient exemption checking process but there has been no formal attempt to ascertain the implications for the rest of that income stream, with respect to regularity of income

From this work I can conclude that the CSA has made substantial improvements in areas previously reported, in particular the area of PV. The CSA has agreed an Action Plan to resolve outstanding matters and any new issues raised by Audit Scotland during the 2002/2003 audit.

3 REPORTS BY THE EXTERNAL AUDITORS

3.1 Internal Controls Report

This report gives details of the matters arising from the External Audit work done in the period January–February 2003 as part of the statutory audit of the Board annual accounts for 2002/2003. It was presented to the Committee in April 2003 as Audit Paper No 03/08.

The report focussed on the following elements of the NHS Board’s financial governance arrangements.

- Internal audit
- Financial management and budgetary control
- Prevention and detection of fraud and corruption
- Legality of financial transactions
- Rotational review of key systems of financial control

The report made 3 recommendations none of which were deemed by the External Auditors to be critical. Actions were agreed and have now been completed to address all 3 recommendations.

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3.2 Follow Up of 2001/2002 Recommendations

This report was presented to the Audit Committee on 28 January 2003 (Audit Paper No 03/03) and set out the results of the External Auditors' follow-up work in respect of all external audit recommendations made in respect of the 2001/2002 audit.

A total of 8 recommendations were made by the External Auditors in their Interim Management Letter and Final Report to Board Members for 2001/2002. Of these 8 recommendations the auditors reported that

- 2 had been fully implemented
- 2 had been partially implemented
- 2 relate to action which is undertaken on an ongoing basis and therefore not subject to a completion date
- one was no longer applicable

In the conclusion to their report, the External Auditors commented that the Board had made good progress in implementing the recommendations from the previous reports.

3.3 Draft Annual Report to Board Members 2002/2003

This report is presented separately to the Audit Committee as Audit Paper No 03/19 and is primarily designed to direct the attention of Board Members to matters of significance which have arisen out of the 2002/2003 audit process. The key points from the Report include the following matters.

The External Auditors' true and fair opinion on the financial statements is unqualified.

The External Auditors are also required to express a regularity opinion on whether in all material respects the income and expenditure shown in the accounts has been applied in accordance with applicable enactments and guidance issued by Scottish Ministers. Their regularity opinion on the income and expenditure is qualified in respect of 2 matters.

(a) Payment Verification

The opinion is qualified due to the absence of a systematic programme of payment verification of Family Health Services expenditure for part of the year. This qualification is technical in nature; while the auditors' concerns relate to matters reported in the Board's accounts, the Board has no direct influence or control over the payment verification process as this is carried out by the Common Services Agency on behalf of the Primary Care Trust. In addition, the auditors note that the expected procedures were in place for the latter part of the financial year.

(b) Non Eligible Payment Exemptions

The opinion is also qualified on the basis of work carried out by the Fraud Investigation Unit which had identified an estimated possible understatement of FHS income of £12.6 million across Scotland in relation to patient charges. While this potential understatement cannot be attributed to specific Trusts, it does indicate that a significant number of incorrect claims for exemption exist.

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BOTH OF THESE MATTERS REQUIRE TO BE DECLARED IN THE SIC

3.4 Private Meeting with Members

In accordance with its Remit and in line with the recommended best practice, the Committee is scheduled to have a discussion with the External Auditors at this meeting without officers of the Board being present.

4 REPORTS BY THE INTERNAL AUDITORS

4.1 Annual Report 2003

The Internal Audit Annual Report is presented separately to the Committee (Audit Paper No 03/17) and includes the following Annual Statement:

“On the basis of work undertaken in the year ended 31 March 2003, we consider that the Board generally has an adequate framework of control over the systems we examined, subject to implementation of the audit recommendations agreed with management. In providing such an opinion we draw your attention to our detailed findings and recommendations as presented in the individual Internal Audit reports issued throughout the year”.

4.2 Assignment Reports 2002/2003

Eight assignments were undertaken by 31 March 2003. A total of 19 recommendations were made:

- 4 were priority 1 (major issues requiring to be brought to the attention of senior management and the Audit Committee)
- 10 were priority 2 (important issues to be addressed by management in their areas of responsibility)
- 5 were priority 3 (minor issues where management may care to consider recommendations)

All 4 priority 1 recommendations related to the audit of the funding of a voluntary agency. The issues raised are being addressed by senior management in a co-ordinated approach covering all directorates.

Further details can be found in the Internal Audit Annual Report presented to this meeting as Audit Paper No 03/17.

4.3 Risk Assessment and Audit Plans

The internal audit plan continues to be based on formal risk assessment. An audit needs assessment was concluded in 1997 following detailed discussions with management and Members. This resulted in a risk and complexity matrix which summarised the risks surrounding each of the Board's main areas of activity. This Matrix has been amended on an ongoing basis to form the basis of the internal audit plans. Work done by the

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Internal Auditors to assist the development of the NHS Board's Risk Management Strategy and Risk Register also informed the audit planning process.

4.4 Private Meeting with Members

In accordance with its Remit and in line with the recommended best practice, the Committee is scheduled to have discussions with the Internal Auditors at the start of this meeting without officers of the Board being present.

5 ASSESSMENT AGAINST FINANCIAL CONTROL STANDARDS

5.1 HDL (2002) 11 introduced the Statement of Internal Control from 2001/2002 and confirmed that the Minimum Financial Control Standards previously published by the Scottish Executive should still be used when assessing financial controls. The Board's system of internal financial control has been assessed against these standards with the detailed results set out in Annex 1.

6 PROGRESS ON RISK MANAGEMENT

6.1 A Risk Management Group was established to progress the development of the Risk Management Strategy and the Risk Register and to prepare for assessment against the Level 1 Standards of the Clinical Negligence and Other Risks Indemnity Scheme. The Group met 16 times throughout 2002/2003 (the high frequency of meetings is reflective of the efforts required to prepare for the CNORIS assessment).

6.2 A workshop attended by senior managers from all Directorates was held in August 2002 which produced the first version of the Risk Register. The Risk Management Group is responsible for ensuring that the Risk Register remains current and live.

6.3 A Risk Management Strategy was developed and approved by the Board in October 2002.

6.4 The NHS Board was assessed against the Level 1 Standards of CNORIS in December 2002. There are 19 standards at Level 1 and all must be achieved for Level 1 accreditation. The Board achieved or exceeded the requirements in 18 of the 19 standards. As only one standard had not been attained (relating to Standards, Use, Storage and Retrieval of Records), the Board was entitled to re-assessment under the fast track process against the remaining standard. In May 2003, the Board passed this re-assessment, thereby achieving the full Level 1 Standard.

<p>THE SIC SHOULD DECLARE THAT THE RISK MANAGEMENT STRATEGY WAS NOT IN PLACE THROUGHOUT THE ENTIRE YEAR AND THAT CNORIS LEVEL I ACCREDITATION WAS OBTAINED IN MAY 2003</p>

7 ANNUAL REVIEW OF CORPORATE GOVERNANCE

7.1 The Board's arrangements for corporate governance are set out in the following documents which are subject to annual review by the Board:

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- Standing Orders for the Proceedings and Business of the Board
- Decisions Reserved for the Board and Remit of Committees
- Scheme of Delegation
- Ethical Standards in Public Life – Code of Conduct for Members
- Register of Board Members Interests
- Standing Financial Instructions
- Diary of Corporate Governance Events
- Fraud and Corruption Response Plan
- Guidance to Support Standards of Business Conduct
- Risk Management Strategy (from October 2002)

7.2 Following the review in April 2001, the Board considered and approved interim governance and committee arrangements in October 2001 to reflect the transition to NHS Greater Glasgow. The review scheduled for April 2002 was deferred until October 2002 to allow the newly-formed committees the opportunity to develop into their new roles and responsibilities before evaluating the new arrangements.

7.3 Reverting to the normal timetable, the corporate governance arrangements and supporting documentation were reviewed and approved by the NHS Board in March 2003.

8 ANNUAL FRAUD REPORT 2002/2003

8.1 The Board's Fraud and Corruption Response Plan was approved by the Board in April 1998 and requires an annual report to be made to the Audit Committee on

- the level of suspected and detected fraud and corruption within the Board and
- the arrangements in place for their prevention and detection.

In 2002/2003, there were no cases of reported or detected fraud or corruption.

8.2 With regard to the arrangements in place to prevent and detect fraud, the Board's anti-fraud policies and procedures are compared against a checklist produced by the Audit Commission for England and Wales to enable organisations to assess the effectiveness of their arrangements in this respect. This comparison indicates that the Board's anti-fraud arrangements were satisfactory during 2002/2003. In their Internal Controls Report (Audit Paper No 03/08 presented in April 2003), the Board's External Auditors reported no significant issues in respect of the Board's arrangements for the prevention and detection of fraud. (The auditors' review identified some exceptions surrounding the expenses payments process operated by North Glasgow University Hospitals NHS Trust on behalf of the Board. These issues have been addressed.)

9 PROPERTY TRANSACTIONS MONITORING 2002/2003

9.1 The NHS Scotland Property Transactions Handbook set out the detailed and rigorous procedures which all NHS bodies in Scotland must follow when conducting any transaction involving property. The Handbook requires post-transaction monitoring to be an integral part of the internal audit programme with the Internal Auditor reporting the results of the monitoring to the Audit Committee which in turn reports to the Board. If

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approved by both the Audit Committee and the Board, the monitoring report is submitted to the Scottish Executive by 31 October each year.

- 9.2 During 2002/2003, only one property transaction was concluded – the sale of 4/5 Lancaster Crescent. The Internal Auditors are currently undertaking their review of this transaction and preliminary indications are that there will be no matters arising from this review (a full report will be presented to the next meeting of the Audit Committee).

10 CLINICAL GOVERNANCE

- 10.1 Following a review of membership, the Clinical Governance Committee now comprises a Non-Executive Director in the Chair and trustees from the 4 existing Trusts, together with a lay representative. Executive Directors of Boards and Trusts attend the meeting but are not members of the Committee. Since this composition was agreed at its meeting in October 2002, the Committee has agreed a remit that is centred around supporting individual Trust Clinical Governance Committees to deal with local issues and identifying areas where collective thinking and decision-making are required.

The Board Committee receives reports from the Trust Clinical Governance Committees and tackles specific topics. Of particular concern in the past year has been development of a unified policy for risk management and the handling of serious clinical incidents. Reports of national audits, in particular the Scottish Trauma Audit report for 2002, and of serious incidents such as Fatal Accident Inquiries, have been considered by the Committee. The Committee has considered audit reports from the colorectal and gynaecological cancer network and has made recommendations in relation to information flows and has considered area-wide arrangements for control of infection within the Board's facilities.

Two committees, in addition to the Trust Clinical Governance Committees, have been established as formal sub-committees of the Health and Clinical Governance Committee. These are the Area Clinical Effectiveness Committee and the Area Control of Infection Committee. Consideration as to the future of an area-wide research governance committee will take place at the next meeting of the Clinical Governance Committee in the light of changing European legislation on the sponsorship of clinical trials.

The role of the Committee in monitoring the clinical staff employed directly by the Board has also been attended to and the Committee has been kept updated on the progress of the appraisal process for public health consultants employed directly by the Board. An annual clinical governance report has been prepared and is presented at Annex 2.

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ANNEX 1

REQUIRED STANDARD		GGNHSB
1	THE CONTROL ENVIRONMENT	Documents marked (*) are included in the Annual Review of Corporate Governance presented to the Board in April each year. All changes to these documents are approved by the Board as part of the Annual Review (see paragraph 5.1)
1.1	Standing Orders are in place	Actioned*
1.2	Standing Financial Instructions are in place	Actioned*
1.3	A scheme of reservation and delegation is in place	Actioned*
1.4	Responsibilities of the Accounting Officer are defined	Actioned The responsibilities of the Accounting Officer are defined in the Appointed Officer Memorandum from the Management Executive
1.5	Standards of Business Conduct for NHS Boards and staff are in place	Actioned The Standards of Business Conduct for NHS Boards and Staff which are contained in MEL (1994) 80 are incorporated into the contract of employment of each Director and employee In addition, supplementary guidance to support these Standards has been issued to assist staff.
1.6	A Fraud and Corruption Policy and Response Plan is in place	Actioned* The Fraud and Corruption Response Plan includes the Board's Fraud and Corruption Policy and is included in the Annual Review of Corporate Governance. Guidance has been issued to staff on the implementation of the Response Plan. In addition, an annual fraud report is produced.

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REQUIRED STANDARD	GGNHSB
1.7 An Audit Committee is in place	<p>Actioned</p> <p>The Audit Committee consists of 5 Non-Executive Directors and the Chairmen of the Trust Audit Committees</p> <p>The Committee met 5 times during 2002/2003, on one occasion the meeting being inquorate</p> <p>The Remit of the Committee is included in the Annual Review of Corporate Governance</p>
1.8 A Remuneration Committee is in place	<p>Actioned</p> <p>The Remuneration Committee is a subcommittee of the Staff Governance Committee and membership consists of the Chairman, 5 Non-Executive Directors and the Employee Director. The Remit is considered as part of the Annual Review of Corporate Governance. The NHS Board and the 4 Trusts have remuneration groups for their respective organisations</p>
1.9 There is an Internal Audit Function in accordance with the NHS Internal Audit Standards	<p>Actioned</p> <p>Internal audit services are provided under contract by a firm of Chartered Accountants. The contract requires the contractor to comply with the NHS Internal Audit Standards</p>
1.10 A performance management system has been established for all staff with financial responsibility which ensures that individuals' objectives flow from the organisation's objectives	<p>Actioned</p> <p>A performance management system for all staff on executive pay grades is operated in accordance with the guidance issued by the Management Executive. Under this system, each individual's objectives cascade down from the Board's objectives</p> <p>A development scheme which incorporates a system of objective setting and performance appraisal applies to staff who are not on General and Senior Managers' pay</p>

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REQUIRED STANDARD	GGNHSB
2 IDENTIFICATION AND EVALUATION OF RISKS AND CONTROL OBJECTIVES	
2.1 There is an annually produced Local Health Plan which includes financial and other performance targets	<p>Actioned</p> <p>The Local Health Plan is presented to the Board annually for approval and includes financial and non-financial targets (eg waiting lists)</p>
2.2 A Risk Management Strategy is in place which includes an assessment of financial risks and the setting of control objectives	<p>A Risk Management strategy was approved by the Board in October 2002</p> <p>The Risk Management Group is responsible for maintaining the Risk Register and meets regularly to consider the management of risk</p> <p><i>These arrangements were not in place and should therefore be declared in the Statement on Internal Control</i></p>
3 INFORMATION AND COMMUNICATION	
3.1 Systems are in place which produce reliable information and proper accounting records	<p>Actioned</p> <p>Established systems and processes were in place for all the Board's key financial activities: payroll, creditors' payments, maintenance of the general ledger and endowments funds</p>
3.2 There is an Information Systems Security Policy in place	<p>Actioned</p> <p>The Information Systems Security Policy is issued to all staff on appointment</p>
3.3 There is an IM&T Strategy in place which covers the Finance Directorate and all significant financial systems	<p>Actioned</p> <p>The Board has developed a Greater Glasgow Information Strategy</p>
3.4 There is a comprehensive budgetary control system in place	<p>Actioned</p> <p>The system of budgetary control is operated includes reporting mechanism to allow budget holders to control expenditure</p>

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REQUIRED STANDARD	GGNHSB
4 CONTROL PROCESSES	
4.1 Procedure notes are in place for all significant and fundamental financial systems	Actioned All significant and fundamental financial systems are covered by a combination of Standing Financial Instructions, procedure notes and manuals
4.2 There is a mechanism in place to control the acquisition, use, disposal and safeguarding of assets	Actioned Standing Financial Instructions specify the processes to be followed to acquire, use, dispose of and safeguard assets. These processes reflect the contents of the NHS Property Transactions Handbook, the Capital Asset Accounting Manual and the NHS Security Manual Furthermore, in January 2003, the Audit Committee approved processes and procedures to support the delegation of capital planning responsibility to NHS Boards under HDL (2002) 40
4.3 There are clearly defined capital and investment control guidelines and formal capital project management disciplines in place	Actioned SFIs set out the controls which apply to capital expenditure and other investment. These controls include the requirement to comply with the Scottish Capital Investment Manual
4.4 There are controls in place to ensure compliance with laws and regulations that have significant financial implications	Actioned SFIs and other governance documents are reviewed on an on-going basis to ensure continued compliance with the law and other regulations

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REQUIRED STANDARD	GGNHSB
4.5 There are arrangements in place to ensure that resources are used effectively, efficiently and economically	<p>Actioned</p> <p>The Board's governance arrangements have been established to ensure that value for money is achieved in all aspects of the Board's operations. These arrangements include:</p> <ul style="list-style-type: none">• regular review of corporate governance to ensure continued compliance with policy• target setting in the Local Health Plan• performance management and oversight by the Remuneration Committee <p>In addition, SFIs place an over-arching obligation on all Directors and employees to secure value for money in all their activities and operations</p> <p>The SFIs and procedure notes for each specific activity set out the detailed processes by which value for money can be achieved</p>
5 MONITORING AND CORRECTIVE ACTION	
5.1 The Board regularly receives and reviews financial and performance reports	<p>Actioned</p> <p>Financial monitoring reports are presented regularly to the NHS Board</p> <p>Reports on non-financial performance are presented to the NHS Board (eg waiting lists, complaints)</p>

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REQUIRED STANDARD	GGNHSB
5.2 The Audit Committee reviews and monitors internal financial control and the implementation of agreed control improvements	Actioned The Audit Committee receives regular progress reports from the Internal Auditors which set out the findings and recommendations from the audit work carried out. Follow up reviews are carried out to ensure that recommendations are implemented as agreed and the results of these are reported to the Audit Committee The External Auditors also report to the Audit Committee on the implementation of previous recommendations
5.3 Policies, procedures and control frameworks are regularly assessed to ensure they remain in line with current guidance and best practice	Actioned SFIs and other governance arrangements are reviewed continuously whenever changes are made to the law or other regulations. Changes in financial procedures are presented to the Audit Committee for approval

Alan Lindsay
Head of Control & Support Systems

Greater Glasgow Health and Clinical Governance Committee Report April 2002 – May 2003

1. Introduction

The Greater Glasgow Health and Clinical Governance Committee was established by the Greater Glasgow NHS Board in 2002, superseding the former Greater Glasgow Clinical Governance Committee. The first meeting of the new committee took place in April 2002, since when meetings have been held on a quarterly basis.

The attached report covers a thirteen-month period from 4 April 2002 to 6 May 2003 during which time five meetings were held. It summarises the topics discussed the resulting action. The appendices to the report detail the remit and current membership of the committee

2. Background

The Greater Glasgow Health and Clinical Governance Committee was established by the Greater Glasgow NHS Board in 2002. Previously, under the Greater Glasgow Health Board, there had been a Greater Glasgow Clinical Governance Committee which met from May 2000 – August 2001.

3. Remit and Membership

The remit and membership of the committee, as approved by the Health Board, are given in appendices I and II.

4. Meetings

The committee met on five occasions. From June 2002 meetings are now held on a quarterly basis. The committee also organised a half-day seminar in October 2002 for members to explore the future agenda.

5. Topics Discussed

5.1 Clinical Governance and the Private Sector

The previous Clinical Governance Committee had initiated a survey on clinical governance policy and practice in private institutions in August 2001, to be carried out by the Nursing Home Registration Department of the Health Board. Following the transfer of responsibility for private institutions to the Care Commission in April 2002, the survey was completed by the Area Clinical Effectiveness Office and the results were discussed by the Health and Clinical Governance Committee in January 2003. The committee was concerned at the incidence of the lack of adequate policies/protocols/guidance in a number of important areas. The report of the survey was forwarded to the Care Commission highlighting the committee's concerns. A response was subsequently received outlining the Commission's perspective and action being taken.

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5.2 Financial Requirements for Clinical Governance (including Clinical Effectiveness)

At its first meeting in April 2002 the committee was made aware of a paper which had been produced by an ad hoc group under the chairmanship of a Trust Medical Director, detailing the financial provision required over a five-year period for the commitments of the Clinical Governance agenda to be fully met throughout Greater Glasgow. The paper had been submitted to the HIP Steering Group, but the proposals were deemed to be unaffordable due to the financial position of the Health Board at that time. The committee decided to keep the issue of adequate financial support for clinical governance/clinical effectiveness under review, and this has subsequently taken place in discussions on Area Clinical Effectiveness Committee proposals (4.3), Trust Clinical Governance Committees and Strategies (4.5) and the report of the Scottish Audit Trauma Group (4.8).

5.3 Area Clinical Effectiveness Committee

Early in 2002 the Area Clinical Effectiveness Committee (ACEC) identified a work programme of audit for six areas within Glasgow's health care system in which there were significant clinical problems. ACEC believed that the proposed projects could have a significant impact on the improvement of patient care and the safety of the service. The projected costs of the projects were substantial and ACEC sought the committee's support in encouraging the Health Board to provide funds (which were subsequently obtained). The status of ACEC was also discussed, and it was decided that ACEC should become a subcommittee of the Health and Clinical Governance Committee. Minutes of meetings of ACEC have been received on a regular basis.

5.4 Post Mortems and Organ Retention

A member of the committee, Mr Morgan Jamieson, reported on the outcome of meetings he had attended dealing with issues relating to post mortems and organ retention.

5.5 Trust Clinical Governance Committees and Strategies

Minutes of meetings of Trust Clinical Governance Committees (TCGC) have been submitted to the committee on a regular basis and presented by TCGC chairmen. Issues noted have included the difficulties experienced by Trusts in supporting Clinical Governance from existing resources. The committee also received copies of the Trust Clinical Governance Strategies and Annual reports (as available).

5.6 Clinical Governance Strategy

The production of a clinical governance strategy on behalf of the committee was among the issues identified at the half-day seminar to discuss the future agenda. Subsequently, Dr Harry Burns, Director of Public Health, prepared a Clinical Governance Strategy document as part of the requirement placed on the Health Board for the visitation of CNORIS (Clinical Negligence and other Risks Indemnity Scheme) for level 1 accreditation. This document was discussed by the committee and a number of recommendations made for its revision, including the highlighting of quality improvement being linked to patient/public partnership. Currently the perspective of the Health Board's Public Involvement Network Management Committee is being sought on this matter, as part of the process of revising the clinical governance strategy document.

5.7 Risk Management and Handling of Serious Clinical Incidents

Risk management and the handling of serious clinical incidents were among the issues identified at the half-day seminar to discuss the future agenda. Trusts were subsequently requested to submit copies of their policies for risk management (including the mechanisms for staff to alert to risks) and the handling of serious clinical incidents. It was felt desirable that there should be a single policy

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document that would set out common strategic principles for the whole of Greater Glasgow, but with flexibility for operational policies to be adopted as appropriate to each Trust. Subsequently the committee became aware that the Greater Glasgow NHS Board Risk Management Strategy document was due for review. Following the meeting on 6 May 2003 the committee recommended to the relevant Health Board department that there should be a single policy document in pursuit of the concept of a pan-Glasgow strategy document. The committee offered to identify individuals to participate in whatever mechanism the Board might set up in pursuit of this.

5.8 Scottish Trauma Audit Group (STAG) – Report 2002

The Area Clinical Effectiveness Committee referred to the committee the final report (for 2002) of the STAG national audit which had been running since 1991. Glasgow had fully participated in the audit and had funded two audit nurses for the purpose of data collection. Notwithstanding the decision taken at national level to discontinue the audit, the committee recommended that the baseline standards data from the audit should continue to be the means used to measure performance in Glasgow as the move took place towards the new two Accident and Emergency department provision. The perspective of the Area Medical Committee Subcommittee in Accident and Emergency has been sought on the recommendation.

Co-incidental with the discontinuance of the STAG audit was the intimation to the committee of the concerns at the lack of available financial resources to enable the North and South Glasgow Trusts to participate in the national hip fracture audit. The committee supported a recommendation that the STAG audit nurses be redeployed to allow the hip fracture audit project to commence. Subsequently, the approval of the Director of the Information and Statistics Division of the Common Services Agency was obtained for this redeployment.

The difficulties of funding Glasgow's participation in the national hip fracture audit illustrated the ongoing and unresolved problem of the lack of available monies in Glasgow to fund important new audit projects. Consequently the committee's concern at the need for this to be addressed was intimated to the Health Board Chief Executive and Director of Finance.

5.9 Fatal Accident Inquiry: Sudden Death from Epilepsy

In the light of the findings of a Fatal Accident Inquiry into the sudden death due to epilepsy of a 17-year old girl, the committee decided that Dr Iain Wallace, Medical Director, Primary Care Trust, should convene a group drawn from each Trust to address the issues in the sheriff's recommendations to ensure a co-ordinated approach involving both primary and secondary care sectors in Glasgow.

5.10 West of Scotland Managed Clinical Network Reports for 2002 – Colorectal and Gynaecological Cancers

Reports were noted and recommendations made to the Network Lead Clinicians that all participating consultants should receive comparative information on figures relating to their work on a yearly basis.

5.11 Area Control of Infection Committee

Commencing at the meeting on 6 May 2003, minutes of the Area Control Infection Committee have been submitted to the committee.

5.12 Appraisal of Greater Glasgow NHS Board Consultants in Public Health

At the meeting on 6 May 2003 the Director of Public Health reported that the process of appraising all Consultants in Public Health employed by Greater Glasgow Health Board was almost complete.

EMBARGOED UNTIL DATE OF MEETING.

5.13 Area Clinical Effectiveness Office Annual Report

The committee received the annual report of the Area Clinical Effectiveness Office for 2001/2. It was recommended that some of the projects reported would be suitable for presentation in papers on health related issues to the Board. Consequently there was submitted to the Health Board at its meeting on 22 October 2002 a report on Geographical Inequalities in Access to Coronary Angiography.

NHS GREATER GLASGOW HEALTH AND CLINICAL GOVERNANCE COMMITTEE

Objectives

1. To ensure that clinical governance mechanisms are in place and effective throughout the NHS Greater Glasgow, including public health at the Board.
2. To ensure that the principles and standards of clinical governance are applied to the health improvement activities of the NHS Board.

Composition

1. The Committee shall comprise 2 non-executive Members from the Greater Glasgow NHS Board, the Chairs of each Trust Clinical Governance Committee and shall have the power to co-opt up to 2 additional Lay Members from outwith the membership of the Greater Glasgow NHS Board.
2. The Chair, Chief Executive, Director of Public Health, Nurse Adviser of Greater Glasgow NHS Board, and Trust Medical Directors, Trust Directors of Nursing and the Chair of the Area Clinical Effectiveness Committee shall be ex-officio Members of the Committee (without voting rights) in order to bring together the professional support required for the Committee to perform its functions.
3. The Trust Chief Executives shall be invited to attend all meetings.
4. The quorum of Meetings of the Health and Clinical Governance Committee shall be 4 voting Members.

Remit

Greater Glasgow Wide

1. The Committee shall systematically review the scope and performance of the Trusts' clinical governance processes and shall have the right (invested in those Committee Members without Trust affiliation) to examine certain aspects of these by receiving reports or taking evidence from those in Trusts responsible for clinical governance.
2. The Committee shall act for the Board in ensuring that the clinical professions
 - (a) engage in effective professional practice;
 - (b) operate so as to support the delivery of high quality care for the population of the Board's area - best met through systematic review of clinical practice;
 - (c) review practice in a systematic manner across Greater Glasgow and identify area-wide issues and consider differences in practice and the reasons for such differences;
 - (d) engage in continuing professional development.
3. The Committee, in conjunction with Trust Clinical Governance Committees, shall identify and monitor issues of common concern for the purpose of setting priorities to be addressed on an area-wide basis.
4. The Committee shall be authorised by the Board to take whatever action is considered necessary to ensure high professional standards are maintained and shall respond promptly to

any adverse reports from staff, patients or the public which question the clinical integrity of any of the Board's activities.

5. The Committee shall participate with other groups as required, such as the Area Clinical Effectiveness Committee and other representative bodies, in discharging its responsibilities.

GGNHS Board Staff

6. The Committee be responsible for oversight of clinical professions employed by the Board as defined in NHS Circular MEL (1978) 75 and MEL (2000)29.
7. The Committee shall oversee the preparation of broadly based performance plans for Board clinical staff (including public health staff at Greater Glasgow NHS Board) prepared on a departmental basis and critically review activity against these plans annually.

Frequency

The Committee will meet 4 times a year, co-ordinating these meeting times with Trust Clinical Governance Committee meetings.

Reporting Arrangements

The Committee shall report its proceedings to the Board, by the submission of the Minutes of meetings and ad hoc papers.

**GREATER GLASGOW NHS BOARD
HEALTH AND CLINICAL GOVERNANCE COMMITTEE**

MEMBERSHIP

Chairman

Professor Michael Farthing

Members

Mrs Hazel Brooke	(Chairman, Yorkhill Trust Clinical Governance Committee)
Mrs Pat Bryson	(Co-opted Lay Member - Convenor, Local Health Council)
Councillor Daniel Collins	(Member, GGNHSB)
Professor Lewis Gunn	(Co-opted Lay Member - Emeritus Professor)
Mr Ian Irvine	(Chairman, North Glasgow Trust Clinical Governance Committee)
Mrs Maire Whitehead	(Chairman, South Glasgow Trust Clinical Governance Committee)
Mr Bob Winter	(Chairman, Primary Care Trust Clinical Governance Committee)

Ex-officio Members

Prof Sir John Arbuthnott	(GGNHSB Chairman)
Mr Tom Divers	(GGNHSB Chief Executive)
Dr Harry Burns	(GGNHSB Director of Public Health and Chairman Area Clinical Effectiveness Committee)
Ms Sue Plummer	(GGNHSB Nurse Adviser)
Dr W G Anderson	(Medical Director, North Glasgow Trust)
Dr Brian Cowan	(Medical Director, South Glasgow Trust)
Mr Morgan Jamieson	(Medical Director, Yorkhill Trust)
Dr Iain Wallace	(Medical Director, Primary Care Trust)
Mrs Ros Crocket	(Director of Nursing, Primary Care Trust)
Miss Maureen Henderson	(Director of Nursing, South Glasgow Trust)
Miss Margaret Smith	(Director of Nursing, North Glasgow Trust)
Miss Brenda Townsend	(Director of Nursing, Yorkhill Trust)

Invited to attend

Mr Jonathan Best	Chief Executive, Yorkhill Trust
Mr Tim Davison	Chief Executive, North Glasgow Trust
Mr Robert Calderwood	Chief Executive, South Glasgow Trust
Mr Ian H Reid	Acting Chief Executive, Primary Care Trust