NHS Greater Glasgow and Clyde

NHS Board **25 June 2019**

Paper 19/34

Chair of the Audit Committee

Governance Statement 2018/19

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 2018/19) 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 2018/19 has been prepared in accordance with this guidance. The statement is attached as Appendix 2

Key Issues to be considered

At its meeting on 18 June 2019, 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 19/35 – 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

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Date June 2019

Statement of Assurance by the Audit and Risk Committee in respect of the system of internal control within NHS Greater Glasgow and Clyde for 2018-19

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 2018-19 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 2018-19;
9. Report on Losses and Compensations 2018-19.

Conclusion

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

"In our opinion NHS Greater Glasgow and Clyde's internal control framework provides reasonable assurance regarding the achievement of objectives, the management of key risks and the delivery of best value, except in relation to:

- *Performance Reporting;*
- *Payroll; and*
- *Sickness Absence.*

Working closely with management, our reviews in the above areas highlighted significant opportunities for improving controls in order to ensure appropriate mitigation of risk, with 9 amber rated (high risk) actions arising. Further detail on these actions is included in the 'Key Findings' section of this report.

Management has committed to implementing the necessary improvement actions in all of the above areas and progress is being reported to the Audit and Risk Committee as appropriate. Our most recent follow-up review for Q4 2018/19 has confirmed that management are making good progress in implementing the actions in line with agreed timescales, and we will continue to monitor this position on a quarterly basis during 2019/20."

Three audit reports identified during 2018-19 were rated as requiring substantial improvement – Sickness Absence, Payroll and Performance 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 2018-19.

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

18 June 2019

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 IFRS 10 – Consolidated Financial Statements, the Financial Statements consolidate the NHSGGC Endowment Fund. This statement includes any relevant disclosure in respect of these Endowment Accounts.

Integration Joint Board 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.

Self assessment of performance

At the Annual Review held in March 2019, the Board assessed its own performance in the presentation of "2017-18 Annual Review Self Assessment". During the year, NHSGGC made significant progress against many of its Local Delivery Plan Standards and across a wide range of strategic programmes.

We delivered against a number of our health improvement objectives as highlighted in the Self Assessment, and either met or exceeded all of our relevant Local Delivery Plan Standards for that year. As detailed in the performance analysis on page 10, 2018-19 has presented

more of a challenge. We have also continued to maximise our role in reducing health inequalities as an employer, procurer, provider and advocate.

Progress has been maintained in delivering against key clinical governance priorities, including clinical risk management, quality of care, patient safety and patient experience. We continued to promptly and effectively respond to the unannounced Healthcare Environment Inspection (HEI) and Older People in Acute Hospital (OPAH) inspection reports.

We did, however, continue to face pressure in relation to achieving our inpatient/day case and new outpatient waiting times standards and a number of workstreams have been established to help deliver immediate and sustainable improvements. Further details on the Board's performance are given in the Performance Report.

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 2018 to 31 March 2019, the Board met on six occasions.

At 31 March 2019 the Board comprised the Chair, twenty-three 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 (SGC) (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 Annual Operational Plan;
- 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, Mr S Carr (Vice-Chair), Cllr J Clocherty, Cllr M Hunter, Ms T McAuley, Ms D McErlean, Ms A-M Monaghan, Mr I Ritchie and Ms A Thompson.

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 five times during 2018-19, and was 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 2018-19, and its members were Mr A Macleod (Chair), Mr S Carr, Mr R Finnie, Ms J Forbes (Vice-Chair), Dr D Lyons, Mr J Matthews, Cllr J McColl and Ms A-M Monaghan. In fulfilling its remit, the ARC was supported by the Audit Committee Executive Group, which met four 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, are 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 meetings 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 2018-19, and its members were Ms S Brimelow (Chair), Cllr C Bamforth, Mr S Carr, Mr A Cowan, Prof A Dominiczak DBE, Mr I Fraser, Dr D Lyons, Ms D McErlean, Mr I Ritchie (Vice-Chair) 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 2019, the membership of the Endowments Management Committee comprised Mr I Ritchie (Chair), Cllr C Bamforth, Mr S Carr, Mr R Finnie (Vice-Chair), Ms J Forbes, Mr A MacLeod, Cllr J McColl, Ms D McErlean, Cllr I Nicolson and Ms R Sweeney. The committee met four times during the year.

Finance and Planning Committee

The remit of the 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 (Vice-Chair from August 2018), Prof A Dominiczak DBE, Mr R Finnie, Ms J Forbes, Mr I Fraser (Vice-Chair till July 2018), Dr D Lyons, Mr A Macleod, Mr J Matthews, Ms T McAuley, Cllr S Mechan, Ms D McErlean, Mr I Ritchie and Ms R Sweeney. The committee met five times during 2018-19.

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. NHS Board members who sat on the Pharmacy Practices Committee were Mr R Finnie (Chair), Mr A Cowan (Vice-Chair) and Mr I Fraser. In addition there are three professional advisers and three lay members. The committee met on three occasions during 2018-19.

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 2018-19 were Mr J Matthews (Chair), Ms M Brown, Mr A Cowan (Vice-Chair), Ms J Donnelly, Cllr M Hunter and Dr D Lyons. In addition there are eight professional advisors who are members of the committee. The committee met four times during the year.

Staff Governance Committee

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 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 2018-19 the committee met on four occasions and was jointly chaired by Ms D McErlean and Ms M Brown. The other members of the committee were Cllr J Clocherty, Mr A Cowan, Ms J Donnelly, Ms T McAuley, 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 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 committee met twice during 2018-19, 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.

The members of the Remuneration Committee were Mr J Brown (Chair), Ms S Brimelow, Mr A Cowan, Mr R Finnie (Vice-Chair), Mr I Fraser, Mr J Matthews and Ms D McErlean.

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 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 within NHSGGC.

Information Governance

Good progress has been made with compliance with the General Data Protection Regulation (GDPR) which came into force in May 2018. An action plan was created which included establishing an Information Asset Register, staff and patient privacy notices and awareness and training for staff. The monitoring of compliance with GDPR continues. Internal audit carried out a review of our compliance with GDPR; they found that significant work had been undertaken to prepare for GDPR requirements, and that management, supported by the Information Governance team, have provided training to Information Asset Owners and staff as well as establishing effective processes for dealing with Subject Access Requests. They also found that Governance arrangements are in place through which GDPR progress is monitored.

The Information Governance Steering Group continues to meet quarterly to monitor IG compliance by reviewing regular reports on data breaches, security compliance, data

protection and records management training and subject access requests. The Group also reviews and approves all new and amendments to relevant policies. The IG Steering Group reports into the ARC.

The organisation has continued to manage and respond to the anticipated rise in Subject Access Requests, with requests being up 10% from previous years.

The IG team continues to provide the necessary support and training to ensure staff are aware of their obligations to protect patient and staff data by continued participation in training programmes, including mandatory training module, new managers training and specific training on data breaches.

A number of communications have been issued to staff to ensure continued awareness and compliance and to remind staff of the availability of support through training and guidance materials located on StaffNet.

In relation to cyber awareness, the National Cyber Security Centre issued ten Cyber Response Early Warning notices which were risk assessed and actioned. An Acceptable Use Policy was implemented and behavioural awareness promoted across the Board. Supporting the Public Sector Action Plan the Board gained Cyber Essentials accreditation for the GP IT environment and the board wide environment. The organisation continues to proactively monitor cyber compliance across staff groups through simulated phishing attacks and targeted training exercises.

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 self-assessment process in line with the requirements of the Blueprint for Good Governance and DL (2019)02. An associated Action Plan has been developed which has been approved by the Board and will be monitored throughout the coming year. The Chief Executive is accountable to the Board through the Chair of the Board. 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.

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 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 am responsible for reviewing the effectiveness of the system of internal control. 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 2018-19 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 Operating Officer chairs monthly meetings of the Strategic Management Group (SMG).
- The Chief Executive chairs a monthly meeting of the Corporate Management Team, attended by the HSCP Chief Officers, 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 the Annual Operational Plan, 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 and review of the Risk Register. In addition the Board Corporate Directors meet weekly in an informal setting. This is also chaired by the Chief Executive and is attended by the Chief Operating 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 2018-19.
- Work has continued during the year to achieve the targets set out in the Annual Operational 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. 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 and will build upon existing good practice and is 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. Due to the complexity and size of the Organisation, each risk had an owner, and is allocated to a specific Committee of Governance, charged with overseeing the management and mitigation of each risk.

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 (as recorded in the CRR) that the Board is managing:

- Achievement of elective waiting time targets in respect of: inpatient/outpatient and day case targets/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.
- Inconsistent assessment and application of Child Protection procedures.
- Inconsistent assessment and application of Adult Support and Protection procedures.
- Management of the recent issues and concerns expressed relating to the QEUH and RHC, including: facilities and environmental issues; capacity flow across the south sector; and media scrutiny regarding patient care.

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.

Health and Safety

Following the Health and Safety Executive (HSE) inspection programme of February and March 2017, work has been on-going across the organisation to implement measures to rectify the contraventions identified. The HSE have received a further update of our HSE Implementation Plan in March 2019 and, although no formal response has been received, it has been agreed that a high level meeting will take place with the Director of Human Resources and Organisational Development, Head of Health and Safety and the HSE to discuss the content of the Plan and the on-going interactions with the organisation. This meeting is due to take place by the end of June 2019.

As part of the initial inspection programme, two Improvement Notices were served with regard to skin health of domestic staff. Both of these Notices have been fully complied with - one in September 2018 and the other in January 2019.

The HSE also served a separate Improvement Notice in November 2018 with regard to the use of respiratory protection and general infection control procedures within infectious diseases wards at QEUH. This Notice was fully complied with in January 2019 and work is on-going to roll out the face fit testing component of this Notice across the wider organization. A report on the progress with this was taken to the Health and Safety Forum in April 2019.

The governance group which monitors progress with the HSE Implementation Plan continues to meet on a monthly basis. Directors are provided with monthly plan updates on compliance, including training compliance data, 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 2019 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 Board's internal auditors completed sixteen audit reviews during the year. There were no grade 4 recommendations raised (very high risk exposure) and no control objectives assessed as "Critical" where there was a fundamental absence or failure of key controls. Overall their reports can be summarised as follows:

- **Red rated – nil:** controls evaluated are not adequate, appropriate, or effective to provide reasonable assurance that risks are being managed and objectives should be met;
- **Amber rated – three:** numerous specific control weaknesses were noted. Controls evaluated are unlikely to provide reasonable assurance that risks are being managed and objectives should be met;
- **Yellow rated – ten:** a few specific control weaknesses were noted; generally however, controls evaluated are adequate, appropriate and effective to provide reasonable assurance that risks are being managed and objectives should be met;
- **Green rated – three:** controls evaluated are adequate, appropriate, and effective to provide reasonable assurance that risks are being managed and objectives should be met.

It is the opinion of the Chief Internal Auditor that the three reports rated as amber should be reported in this Governance Statement; these reports are:

- **Sickness absence**
  Audit conclusion - the internal auditors recognised we have created a robust framework for managing sickness absence. They identified through sample testing, that in some cases managers and supervisors are not consistently using this information and adhering to documented processes to manage absences at both individual and team levels. They highlighted that absences may not be managed effectively in every instance which could prevent NHSGGC from lowering absence rates across the Board.

  Management response - actions have been identified, and agreed with managers, to ensure compliance with procedures and to improve the quality of data on sickness absence that will help the Board to improve its performance in this area.

- **Payroll**
  Audit conclusion – the audit review identified a number of weaknesses within NHSGGC's payroll procedures. These covered a number of different areas including the processing of amendments, staff bank payments, medical on-call supplements and Waiting List Initiative sessions.

  Management response - the capabilities of our new HR system, electronic Employees Support System (eESS), will help the Board address many of the recommendations raised in this report and should also improve the efficiency of the payroll processes.

- **Performance reporting**
  Audit conclusion – the internal auditors noted that whilst performance management arrangements in NHSGGC reflect good practice in many areas, there was significant room for improvement in some respects. NHSGGC had an 'Interim Annual Plan' in place for 2018-19 that set out the board's objectives for the year. This plan was put in place as an interim measure following the Scottish Government's suspension of the Annual Delivery Plan process and in recognition of the impact that MFT will have in shaping the strategic agenda.

  The plan was supplemented by a performance management plan that contained supporting actions and targets for measuring delivery of those objectives. The objectives and targets identified provide adequate coverage over the main activities of the health board and comprise an appropriate mix of qualitative and quantitative indicators. This enables NHSGGC to monitor their performance throughout the current year.

  Management response - significant enhancements have been identified that can be made to the performance management process to improve how performance against objectives is measured and reported. The auditors recommended that we produce a comprehensive performance framework to ensure organisation-wide performance is robustly measured and reported on. This includes ensuring all targets are SMART and contain adequate detail around how they will be delivered. This framework will support the production of performance reports that provide substantial assurance to the NHSGGC Board and minimise reporting duplication across the organisation.

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.