NHS Greater Glasgow & Clyde	**Paper No. 20/46**
Meeting:	**NHSGGC Board**
Date of Meeting:	**29th September 2020**
Purpose of Paper:	**For Approval**
Classification:	**Board Official**
Sponsoring Director:	**Chair of Audit and Risk Committee**

Governance Statement 2019/20

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 2019/20) 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 2019/20 has been prepared in accordance with this guidance. The statement is attached as Appendix 2

Key Issues to be considered

At its meeting on 22nd September 2020, 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 20/45 - but for ease of reference, a copy is also attached here at Appendix 2).

Any Patient Safety /Patient Experience Issues

None

Any Financial Implications from this Paper

None

Any Staffing Implications from this Paper

None

Any Equality Implications from this Paper

None

Any Health Inequalities Implications from this Paper

None

Has a Risk Assessment been carried out for this issue? If yes, please detail the outcome.

None

Highlight the Corporate Plan priorities to which your paper relates

Improving quality, efficiency and effectiveness

Author Financial Governance Manager

Tel No 0141 201 4737

Date September 2020

NHS Greater Glasgow & Clyde

Audit and Risk Committee **22nd September 2020**

Financial Statements 2019/20 - Review of System of Internal Control

Recommendation

Members are asked to;

1. Note the summary of the System of Internal Control within NHS Greater Glasgow and Clyde outlined below, and the detail contained within the Annual Report and Consolidated Statements;
2. Approve for submission to the NHS Board on 29th September 2020 the Statement of Assurance by the Audit and Risk Committee at Appendix 1;
3. Approve the Governance Statement contained in the draft Directors' Report of the Financial Statements for submission to the NHS Board on 29th September 2020 with a recommendation that the Chief Executive, as Accountable Officer, signs the Governance Statement;
4. Note the agreed position at the 8th September 2020 Audit Committee that the Chair of the Audit and Risk Committee would notify the Health and Social Care Assurance Board that there were no significant issues of fraud.

Purpose of Paper

As Accountable Officers, Chief Executives of NHS Boards have responsibility for maintaining a sound system of internal control within their organisations and are required, as Accountable Officers, to sign a Governance Statement as part of the annual accounts.

The purpose of the Governance Statement is to describe the effectiveness of the organisation's system of internal control; it is not restricted to internal financial controls but considers all aspects of the system of internal control including clinical governance, staff governance, information governance and risk management. If any significant aspect of the system of internal control is found to be unsatisfactory, this should be disclosed in the Governance Statement.

Guidance issued by the Scottish Executive states that NHS Boards are responsible for reviewing the effectiveness of the system of internal control having regard to assurances obtained from the Audit and Risk Committee and any other standing committee which reviews the operation of the NHS Board's system of internal control as part of its delegated authority.

The current remit of the Audit and Risk Committee states that;

"The Audit and Risk Committee will provide the Board and Accountable Officer with an annual report on the Board's system of internal control, timed to support finalisation of the Statement of Accounts and the Statement on Internal Control. This report will include a summary of the Committee's conclusions from the work it has carried out during the year."

The format and contents of the Governance Statement are specified in annual guidance issued by the Scottish Government. The Governance Statement for 2019/20 has been prepared in accordance with this guidance.

Key Issues to be considered

Review of System of Internal Control

The Audit and Risk Committee can draw upon a number of sources to inform its review of the system of internal control and these are detailed throughout the Governance Statement. On the basis of the assurances obtained from these sources, the report concludes that, overall, a satisfactory system of internal control was in place within NHS Greater Glasgow and Clyde throughout 2019/20. There were, however, some control issues that require to be reported in the Governance Statement.

Statement of Assurance

The Audit and Risk Committee is required to report to the NHS Board on the outcome of its review of the system of internal control and its report should include a recommendation on matters which are required to be declared or referred to in the Governance Statement. A draft Statement of Assurance (Appendix 1) has been prepared for submission to the NHS Board by the Chair of the Audit and Risk Committee based on the above conclusion from the Review of the System of Internal Control.

Notification to the Chair of the Health and Social Care Assurance Board

The Scottish Public Finance Manual requires Audit Committees of Sponsored Bodies to notify the Health and Social Care Assurance Board of any significant issues that are considered to be of wider interest. Chairs of NHS Boards' Audit Committees are therefore requested to provide details of any significant issues or frauds which arose during 2019/20 that they consider should be brought to the attention of the Health and Wellbeing Audit Committee.

At the Audit Committee of 8th September 2020, it was discussed and agreed that, based on the review of the system of internal control and the Annual Fraud Report 2019/20, it is considered that, other than the matters referred to above requiring to be disclosed in the Governance Statement, there are no significant matters which require to be reported to the Health and Social Care Assurance Board. The Director of Finance has done this by email.

Any Patient Safety /Patient Experience Issues

None noted

Any Financial Implications from this Paper

None noted

Any Staffing Implications from this Paper

None noted

Any Equality Implications from this Paper
None noted

Any Health Inequalities Implications from this Paper
None noted

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

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

Author; Director of Finance

Date; 20th September 2020

APPENDIX 1

Statement of Assurance by the Audit and Risk Committee in respect of the system of internal control within NHS Greater Glasgow and Clyde for 2019/20

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 2019/20 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 2019/20;
9. Report on Losses and Compensations 2019/20.

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:*
>
> - *Service Redesign – Acute Stroke Services;*
> - *Operational Planning;*
> - *Medicines Reconciliation in Hospital;*
> - *Sickness Absence Follow Up; and*
> - *IT Security.*

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 15 amber rated (high risk) actions arising. We also identified a number of potential causes behind delays in implementing the Moving Forward Together plan.

Management has committed to implementing the necessary improvement actions in all of the above areas and progress is being reported regularly to the Audit and Risk Committee. More recently, management has committed to accelerating progress in a number of areas as part of a wider remobilisation plan post Covid-19. Our most recent follow-up review for Q4 2019/20 confirmed that management are making excellent progress in implementing the actions in line with agreed timescales, and we will continue to monitor this position on a quarterly basis during 2020/21.

We were able to provide substantial assurances in the remaining ten audit areas covered during 2019/ 20, all of which were assessed as either "effective" or with only "minor improvement required". We did not identify any grade 4 (very high risk) actions.

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 2019/20.

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

22nd September 2020

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.

IJB Accounts

In accordance with IFRS 11 – Joint Arrangements, the Financial Statements consolidate the IJB Accounts of Glasgow City, 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 that year, NHSGGC had made significant progress against many of its Local Delivery Plan (LDP) Standards and across a wide range of strategic programs.

We delivered against a number of our health improvement objectives as highlighted in the Self-Assessment, and either met or exceeded the relevant LDP Standards for that year. We also maintained our best in class position amongst other territorial Health Boards by continuing to exceed the target for the number of eligible referrals to our Psychological Therapies that started their treatment within 18 weeks of referral. Whilst we made positive progress against a number of LDP Standards there were a number of key performance areas that remained challenging in 2018-19 and into 2019-20.

In November 2019 in light of what was described as on-going issues around the systems, processes and governance in relation to infection prevention, management and control at the QEUH and RHC and the associated communication and public engagement issues, the Board was escalated to Stage 4 of the NHS Scotland Board Performance Escalation Framework, and in January 2020 the Board was further escalated to Level 4 of the NHS Scotland Board Performance Escalation Framework in respect of scheduled care, unscheduled care, primary care out of hours and culture and leadership. A number of improvements were subsequently made against some of the key challenging areas. For example, prior to the outbreak of Covid-19, NHSGGC had been making steady progress towards the delivery of the key access targets by March 2020 and on course to deliver the agreed TTG and new outpatient targets set for 31 March 2020 (8,500 TTG and 19,800 Outpatients over 12 weeks). However, in preparation for, and in response to, the Covid-19 outbreak, all routine elective work was temporarily suspended across Scotland on a phased basis from the week beginning 16 March 2020.

In 2019-20 we also continued to maximise our role in reducing health inequalities as an employer, procurer, provider and advocate. Progress was also made 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.

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 2019 to 31 March 2020, the Board met on seven occasions.

At 31 March 2020 the Board comprised the Chair, twenty-five 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.

During 2019-20, NHSGGC faced a number of significant challenges, including responding to the Covid-19 pandemic. The Board has also taken a range of actions to respond to the reviews and upcoming Inquiry related to the QEUH campus, and to escalation to Stage 4 of the NHS Scotland Board Performance Escalation Framework. The Board has continued to take actions to enhance governance arrangements with a focus on implementing the Blueprint for Good Governance. To support this the Board constituted a number of member-led Short Life Working Groups to progress the Board Development Plan, focussed upon Moving Forward Together (MFT), Unscheduled Care, Board Members' Skills, Board Papers, and Assurance Information.

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

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, Planning and Performance Committee (FPPC);
- Pharmacy Practices Committee;
- Public Health Committee; and
- Staff Governance Committee (SGC) (including Remuneration Sub-committee).

Additionally, in response to the Covid-19 outbreak, the Board of NHSGGC determined in a virtual Board meeting which took place between 19th and 23rd March 2020 to institute a committee to be referred to as the Interim Board to undertake all delegable business of the full Board during the outbreak, subject to review by the full Board at its meeting scheduled for 30 June 2020.

The membership of the Interim Board was determined as 8 Non Executive members (including Chair and Vice Chair of the Board, chairs of standing committees, and representation of stakeholder members) and 2 executive members. The first meeting of the Interim Board took place on 8 April 2020.

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 Finance, Planning and Performance Committee);
- 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 five times during the year 2019-20. Members of the Committee during the year were Mr R Finnie (Chair), Ms S Brimelow, Mr S Carr (Vice-Chair), Cllr J Clocherty, Cllr M Hunter, Ms M Kerr, Ms A Khan, 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 six times during 2019-20, 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 2019-20, and its members were Mr A Macleod (Chair), Mr S Carr, Mr R Finnie, Ms J Forbes (Vice-Chair), Dr D Lyons, Ms M Kerr, Mr J Matthews, Cllr J McColl and Ms A-M Monaghan. In fulfilling its remit, the Committee 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 2019-20, and its members were Ms S Brimelow (Chair), Cllr C Bamforth, Mr S Carr, Prof A Dominiczak DBE, Dr D Lyons, Ms D McErlean, Mr I Ritchie (Vice-Chair) and Ms A Thompson.

Endowments Management Committee

Responsibility for the Board's Endowment Funds lies with the Trustees, who are all members of the Board. The Trustees have delegated to the Endowments Management Committee roles of disbursing funds, reviewing proposals, 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 2019-20, the membership of the Endowments Management Committee comprised Mr I Ritchie (Chair), Cllr C Bamforth, 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 five times during the year.

Finance, Planning and Performance Committee

The remit of the FPPC is to oversee the financial and planning strategies of the Board, oversee performance of Board functions, 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 FPPC comprises the following core elements:

- Finance and Planning;
- Performance;
- 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 Committee further receives performance monitoring information related to all functions within the Health Board system.

The members of the FPPC during 2019-20 were Mr J Brown (Chair), Ms S Brimelow, Mr S Carr, Mr A Cowan, Prof A Dominiczak DBE, Mr R Finnie, Ms J Forbes, Dr D Lyons, Mr A Macleod, Mr J Matthews, Cllr S Mechan, Ms D McErlean, Mr I Ritchie and Ms R Sweeney. The Committee met six times during 2019-20.

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) Ms M Kerr (Vice-Chair) and Cllr I Nicolson. In addition there are three professional advisers and three lay members. The Committee met on six occasions during 2019-20.

Public Health Committee

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

Members of the Committee during 2019-20 were Mr J Matthews (Chair), Mr A Cowan (Vice-Chair), Ms J Donnelly, Cllr M Hunter, Ms A Khan, Dr D Lyons and Mr I Ritchie. In addition there are eight professional advisors who are members of the Committee. The Committee met four times during 2019-20.

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 2019-20 the SGC met on four occasions and was jointly chaired by Ms D McErlean and Mr A Cowan. The other members of the committee were Cllr J Clocherty, Ms J Donnelly, Cllr S Mechan, Ms R Sweeney, Mrs A Thompson and Ms F Tudoreanu.

The Remuneration Committee is a sub-committee of the SGC and its main role is to ensure the application and implementation of fair and equitable systems for pay and for performance management on behalf of the Board as determined by Scottish Ministers and the Scottish Government Health and Social Care Directorate (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 Remuneration Committee met twice during 2019-20, 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 during 2019-20 were Mr J Brown (Chair), Ms S Brimelow, Mr A Cowan, Mr R Finnie (Vice-Chair), Mr J Matthews, Ms D McErlean and Mr I Ritchie.

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 Finance, Planning and Performance Committee and the Acute Services Committee. Regular reports on the Board's financial position are considered by these groups. The Audit and Risk Committee 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.

The Information Governance (IG) Steering Group continues to meet quarterly to monitor Information Governance 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 to the Audit and Risk Committee.

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 Staff Net.

The National Cyber Security Centre issued six Cyber Response Early Warning notices which were risk assessed and actioned. As part of its implementation of the Network Information Systems (NIS) Regulations the Board published an updated suite of Information Security Policies. Risk assurance was carried out for twelve systems and a new risk triage process introduced. Internal user awareness was carried out through a combination of core brief, policy promotion and simulated phishing attacks.

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 organization'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 seven times during 2019-20 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, Facilities and Estates, and Communications, as well as the Employee Director. The focus of the group includes the development of proposals for the Board on financial and capital allocations and the AOP, 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 which 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.
- Work has continued during the year to achieve the targets set out in the AOP. 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.
- An on-line performance 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 framework for the management of risk. The framework is proactive in identifying and understanding risk and will build upon existing good practice. As a Board we continue to strive to make Risk Management 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 Corporate Risk Register summarises the main risks identified within each of the

organisational areas, and the processes by which these risks are being managed, and is presented to the ARC for approval on a six-monthly basis.

During the year, the Corporate Risk Register (CRR) was updated to include a range of risks and controls in relation to the Independent External Review of the QEUH and the upcoming Public Inquiry. In addition, a Covid-19 specific Risk Register was drafted and is reviewed regularly by the Covid-19 Senior Executive Team and the Covid-19 specific Board meeting.

Other developments included the recruitment of a dedicated Senior Risk Officer for the Board with the primary objective of overseeing the whole Risk Management process and making improvements where necessary.

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;
- sanctioned the appointment of a Senior Risk Officer for the Board;
- 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, particularly in light of Covid-19 and the requirement to prioritise urgent care, provide PPE, manage social distancing and protect shielded patients.
- Achievement of unscheduled care targets in respect of: managing emergency patient flows; and managing the impact on downstream bed management, particularly in light of the Covid-19 challenges outlined above.
- 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, accentuated by Covid-19 spend, unlikely to be met through Cash Releasing Efficiency Savings (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.

The following are the highest risk rated areas recorded in the Covid-19 specific Risk Register. It should be noted this is a rapidly changing situation and these risks are correct at the time of drafting this report:

- There is a risk that routine processes for ensuring quality and safety through clinical governance become overwhelmed;
- There is a risk that demand for inpatient beds, including ICU, will outstrip availability and impact of patient safety.
- Staff absence due to isolation either by being symptomatic or having a household member who is symptomatic or falling into the Shielding categories and insufficient supply of additional staff to cover absences and increase in overall activity.
- Negative impact of staff wellbeing.
- There is a risk due to fast moving guidance changes of what type of Personal Protective Equipment (PPE) is required means demand and supply do not match, and/or that there is insufficient PPE in the right areas at the right times.
- As COVID infection rates increase in care homes there are increasing risks in terms of capacity, PPE, staffing impacting on both hospital and community services with an increase in deaths in care homes. Significant media interest nationally.

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

The health, safety and wellbeing of our staff remains a high priority.

The Board has in place a 3-year staff health strategy and this has had a positive impact on the health and wellbeing of our staff. Following a Board wide survey of our staff, the new 3 year strategy will be launched this year. A particular focus for this will be supporting our staff with mental health issues which have resulted from the Covid-19 pandemic.

We continue to work with the Health and Safety Executive (HSE) and we have received 3 further improvement notices. Two of these are in relation to staff compliance with training programmes and one is regarding concerns about ventilation. The Board has contested the ventilation improvement notice and this is being progressed through a legal process.

We have supported staff through the Covid-19 pandemic and we have been very proactive in issuing appropriate levels of PPE. A number of wellbeing initiatives have been launched to support staff during this time.

We are actively supporting the health and wellbeing of our staff in the recovery phase of the pandemic by planning and implementing changes to offer increased protection to our staff and comply with Scottish Government guidance.

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 2020 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.

Annual Service Reports

Annual Service Audit Reports are designed to provide assurance around the internal controls frameworks operated on behalf of NHS Scotland by NHS National Services Scotland (NSS). These services are Practitioner and Counter Fraud Services (PCFS) for payment of family health services practitioners, Atos and NSS Digital and Security to support national IT services, and NHS Ayrshire and Arran for National Single Instance ledger services.

For the year 2019-20, the Service Audit report in relation to NSI financial ledger was unqualified. The new Service Auditors for the PCFS and IT services have applied the standards and approach defined in ISAE 3402 in full. Findings identified, whilst consistent with those identified in previous years, have this year resulted in a qualified opinion.

A number of low risk improvements were highlighted to NHS National Services Scotland primarily focussed around evidence gathering from some legacy systems, The Board has received assurances from NSS that each point raised within the reports will be addressed as part of their continuous improvement programme of work. This Board do not believe that these findings have any material impact on this Boards accounts and assurance

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 – five:** 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 – seven:** 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.
- **Not graded – one**: advisory review looking at the progress of ongoing projects/work, where gradings are not assigned but comment given on progress, good practice and recommendations made for areas of future focus.

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

- **Service Redesign – Acute Stroke Services**
  Audit conclusion - The auditors identified a lack of key project management arrangements to ensure the successful implementation of the redesign work.
  Management response - We agreed on a number of improvement actions to better enable NHSGGC to develop robust project governance arrangements across the life of the service redesign work, and particularly in the context of potentially changing project objectives.

- **Operational Planning**
  Audit conclusion – The internal auditors noted NHSGGC has a number of operational planning documents in place designed to support achievement of Scottish Government healthcare priorities and Board level strategic and transformational plans. They also found however that there was not consistent, demonstrable linkage between each of these plans from an operational perspective, or in their collective contribution towards the Board's strategic objectives.
  Management response – The internal auditors recommended actions to demonstrate the contribution of operational priorities to achievement of wider strategic objectives and facilitate a consistent approach across NHSGGC. This will allow NHSGGC to improve its overall control framework in this area and better mitigate the risk of non-achievement of both strategic and operational objectives

- **Medicines Reconciliation**
  Audit conclusion – Before this work commenced, management highlighted known issues around compliance with application of the Medicines Reconciliation in Hospital Policy. The auditors identified a number of areas that could be improved to support more uniform application of the Policy.
  Management response – We agreed actions to prioritise implementation of the identified improvement actions to address the current issues of non-compliance with the Medicines Reconciliation Policy in order to realise the maximum possible benefit from the HePMA rollout; and ensure ongoing patient safety.

- **Sickness Absence Follow Up**
  Audit conclusion – During this follow-up review, the auditors found that individual and team compliance with the process is still inconsistent. They also noted that the delayed release of revised national guidance has hindered ongoing improvement activity on absence

management but despite this, progress has been made in implementing the recommendations previously raised.
Management response – NHSGGC has now established a framework for improvement initiatives, designed specifically to identify and address the root causes of sickness absence. We have confirmed that this activity is beginning to yield results in some areas of the organization and have agreed actions to improve upon current results.

- **IT Security**
  Audit conclusion – The audit identified ongoing risks to the organisation, both internal and external. Weaknesses were noted in process and documentation for privileged and generic accounts reviews as part of a wider Active Directory user access, including the need to improve logging and monitoring of activity vulnerabilities identified by Cisco Advanced Malware Protection.
  Management response – We agreed on specific management actions in relation to leavers processes and user access to systems. We agreed to evaluate the operational impact of enabling AD audit logging (possibly Domain Controller performance) and the detail requiring to be retained, for what period. We will work to improve upon both internal and external factors identified to improve our IT Security.

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