MODEL CORPORATE GOVERNANCE ATTESTATION STATEMENT FOR LOCAL HEALTH DISTRICTS AND SPECIALTY NETWORKS

Background

Public Health Organisations are required to complete an Annual Corporate Governance Attestation Statement as part of good corporate governance practice as referred by Central Agencies and External agencies like the Audit Office of NSW and as referred in the NSW Health Corporate Governance and Accountability Compendium. The requirement also forms part of the LHDs obligations under the Service Agreement (Schedule F)

Completion Instructions:

Local Health Districts (LHDs) and Specialty Networks (SNs) should use the text provided in the '*Model Corporate Governance Attestation Statement for LHDs and SNs*' (attached) as the basis for their Corporate Governance Attestation Statement. Corporate Governance Attestation Statements report retrospectively by financial year.

The Corporate Governance Attestation Statement (including qualifications and any explanatory notes) should be:

- Prepared by the Chief Executive and tabled at the Audit and Risk Management Committee of the LHD/SN;
- endorsed by the Board and signed by the Board Chairperson;
- published in full on the LHD/SN Internet site
- a copy of the statement is provided to the Corporate Governance and Risk Management Unit, Ministry of Health by 31st August 2019.

The Model Statement is designed to support the Organisation's CORE values and structures and address the seven governance standards outlined within the NSW Health Corporate Governance and Accountability Compendium. Organisations must include within their Statement all information contained in the Model Statement as a minimum. Organisations may add information to the Statement as relevant to local needs in order to promote their governance activities to any stakeholders that may be interested in the content of the statement. Text requiring insertion or editing is identified as **blue** within the Model Statement.

Where an organisation has not implemented or met the requirements identified in the Model Statement, the supplied text may be edited to reflect the implementation status within the Organisation, and explain within the Qualifications page the actions to be taken or, provide information to the Ministry of Health explaining the reasons why the requirement has not been met or implemented, and the actions proposed to rectify the identified non-compliance. Where information is not relevant to the business of the Organisation it may be removed.

Appropriate working papers and records should be maintained to support the content included within the Statement and for audit purposes.

The Statement may be 'desktop published' or otherwise redesigned to reflect the Organisation's preferred publication format. The Statement may also be redesigned in order to be published in full on the Internet as long as the content of the Statement is not compromised.

For further information about the content of the Statement and its completion and submission, please contact the Director, Corporate Governance and Risk Management, Legal and Regulatory Services Branch, in the Ministry on (02) 9391 9654 or at MOH-CGRM@health.nsw.gov.au.

Corporate Governance Attestation Statement for
South Eastern Sydney Local Health District
1 July 2018 – 30 June 2019

CORPORATE GOVERNANCE ATTESTATION STATEMENT
South Eastern Sydney Local Health District

The following corporate governance attestation statement was endorsed by a resolution of the South Eastern Sydney Local Health District Board at its meeting on 31 July 2019 on the basis that the Chief Executive has conducted all necessary enquiries and is not aware of any reason or matter why the Board cannot give the required attestation.

The Board is responsible for ensuring effective corporate governance frameworks are established for the South Eastern Sydney Local Health District and not the day-to-day management of the Organisation. To this end, the Board is satisfied and has received assurances from the Chief Executive that the necessary processes are in place

This statement sets out the main corporate governance frameworks and practices in operation within the South Eastern Sydney Local Health District for the 2018-2019 financial year.

This attestation statement has been reviewed by Internal Audit to ensure the South Eastern Sydney Local Health District has implemented and met all necessary requirements. Each section within the attestation statement is supported by relevant and complete documentation, which has been reviewed and signed off by the Chief Audit Executive.

A signed copy of this statement is provided to the Ministry of Health by 31 August 2019.

Signed:

Michael Still
Chairperson

Date 31 July 2019

Tobi Wilson
Chief Executive

Date 1.8.19

Standard 1: ESTABLISH ROBUST GOVERNANCE AND OVERSIGHT FRAMEWORKS

Role and function of the Board and Chief Executive

The Board and Chief Executive carry out their functions, responsibilities and obligations in accordance with the *Health Services Act 1997* and the *Government Sector Employment Act 2013*.

The Board has approved systems and frameworks that ensure the primary responsibilities of the Board are fulfilled in relation to:

- Ensuring clinical and corporate governance responsibilities are clearly allocated and understood
- Setting the strategic direction for the SESLHD and its services
- Monitoring financial and service delivery performance
- Maintaining high standards of professional and ethical conduct
- Involving stakeholders in decisions that affect them
- Establishing sound audit and risk management practices.

Board meetings

For the 2018/2019 financial year, the Board consisted of a Chairperson (Michael Still) and 12 members appointed by the Minister for Health. The Board met 10 times during this period.

Authority and role of senior management

All financial and administrative authorities have been appropriately delegated by the Chief Executive with approval of the Board and are formally documented within a Delegations Manual for SESLHD *(Please refer to Item 1 in the qualification section for further details).*

The roles and responsibilities of the Chief Executive and other senior management within SESLHD are also documented in written position descriptions.

Workforce Services will arrange for future position descriptions to incorporate leadership and accountability responsibilities for Aboriginal Health *(Please refer to Item 2 in the qualification section for further details).*

Regulatory responsibilities and compliance

The Chief Executive is responsible for and has mechanisms in place to ensure that relevant legislation, regulations and relevant government policies and NSW Health policy directives are adhered to within all facilities and units of SESLHD, including statutory

reporting requirements.

The Board has mechanisms in place to gain reasonable assurance that SESLHD complies with the requirements of relevant legislation, regulations and relevant government policies and NSW Health policy directives and policy and procedure manuals as issued by the Ministry of Health *(Please refer to Item 3 in the qualification section for further details).*

Standard 2: ENSURING CLINICAL AND CORPORATE GOVERNANCE RESPONSIBILITIES ARE CLEARLY ALLOCATED AND UNDERSTOOD

The Board has in place frameworks and systems for measuring and routinely reporting on the safety and quality of care provided to the communities SESLHD serves.

These systems and activities reflect the principles, performance and reporting guidelines as detailed in the NSW Health policy directive '*Patient Safety and Clinical Quality Program'* (PD2005_608). The Principles underpinning the Patient Safety and Clinical Quality Program as outlined in the Clinical Excellence Commission Directions Statement are:

- Openness about failures
- Emphasis on learning
- Obligation to act
- Accountability
- Just culture
- Appropriate prioritisation of action
- Teamwork and information sharing

A Medical and Dental Appointments Advisory Committee is established to review the appointment or proposed appointment of all visiting practitioners and specialists. The Credentials Subcommittee provides advice to the Medical and Dental Appointment Advisory Committee on all matters concerning the scope of practice and clinical privileges of visiting practitioners or staff specialists.

SESLHD has a Safety and Quality Board Committee (SQBC) with its primary purpose to ensure that the Local Health District has appropriate patient safety and clinical quality systems to monitor performance and to continuously improve patient care. The Safety and Quality Board Committee is responsible for the governance of the NSW Health Patient Safety and Clinical Quality program within the District and provides assurance to the Board on matters relating to patient safety and clinical quality.

SESLHD has also established an Aboriginal Health Plan Implementation Committee which operates as an Advisory Committee and is responsible:

- To provide leadership for the Implementation of the NSW Aboriginal Health Plan 2013-2023; and the NSW State Health Plan towards 2021 for elements relating to Aboriginal Health.
- To monitor the implementation of the above Plans as relevant.
- To monitor implementation of the Ministry of Health Policies, National Partnership

Agreements (as relevant) and new local initiatives pertaining to Aboriginal health in SESLHD.
- To improve the reporting of health service provision and health outcomes for Aboriginal people.
- To oversight improvement in the performance of Aboriginal Health Indicators in health services facilities located in SESLHD.

The Chief Executive has mechanisms in place to ensure that the relevant registration authority is informed where there are reasonable grounds to suspect professional misconduct or unsatisfactory professional conduct by any registered health professional employed or contracted by SESLHD.

In addition, SESLHD has an established Clinical Governance Unit (CGU) which provides a range of services to the District and facilities in order to support the NSW Health Patient Safety and Clinical Quality Program (PD2005_068). It does so through delivery of the following core functions:

- National Standards and Accreditation
- Incidents and Complaints Management
- Audits of Clinical Performance
- Improvement science
- Patient Safety Program
- Safety Alerts and Product Recalls
- Oversight of Compliance with Policy

SESLHD also has effective forums in place to facilitate the involvement of clinicians and other health staff in decision making.

Standard 3: SETTING THE STRATEGIC DIRECTION FOR THE ORGANISATION AND ITS SERVICES

The Board has in place strategic plans, such as a Local Health Services Plan, for the effective planning and delivery of its services to the communities and individuals served by the SESLHD. This process includes setting a strategic direction for both SESLHD and the services it provides within the overarching goals and priorities of the *NSW State Health Plan*. The SESLHD site-specific clinical services plans include:

The SESLHD site-specific clinical services plans include:

- The Greater Randwick Integrated Health Services Plan
- St George Integrated Health Services Plan 2018
- Sutherland Hospital and Community Health Services Integrated Health Services Plan 2019
- The Royal Hospital Strategic Plan 2014-2020

Organisational-wide planning processes and documentation is also in place, with a 3 to 5 year horizon, covering:

a Asset Strategic Plan 2018 – Designing and building future-focused infrastructure.

The 2018 Asset Strategic Plan was finalised with the relevant Asset Strategic Plan schedules updated annually in accordance with the requirements of the Ministry of Health.

b SESLHD ICT Strategy – 2017-2022 – Enabling eHealth

c SESLHD Research Strategy 2017-2021 – Supporting and harnessing Research and Innovation

d Workforce Services Strategic Plan 2018-2021 – Supporting and developing our workforce

e Aboriginal Health Action Plan 2018 -2022 – Ensuring health needs are met competently

f Corporate Governance Plan – *Please refer to item 4 in the qualification section for further details.*

The strategic priorities for SESLHD have been documented in the Journey to Excellence Strategy 2018-2021 document. The Strategy has been developed in partnership with SESLHD staff and community to guide SESLHD towards transformational change over the next three years and beyond. Each strategic priority within the strategy has been assigned several Outcome Measures. These measures have been designed as 'stretch' goals. SESLHD has intentionally listed the Outcome Measures as 'stretch' goals so that our people can think and act in a transformational way.

Standard 4: MONITORING FINANCIAL AND SERVICE DELIVERY PERFORMANCE

Role of the board in relation to financial management and service delivery

SESLHD is responsible for ensuring compliance with the NSW Health Accounts and Audit Determination and the annual Ministry of Health budget allocation advice.

The Chief Executive is responsible for confirming the accuracy of information in the financial and performance reports provided to the Board and those submitted to the LHD/SN Finance and Performance Committee and the Ministry of Health, and that relevant internal controls for SESLHD are in place to recognise, understand and manage its exposure to financial risk.

The Board has confirmed that SESLHD has in place systems to support the efficient, effective and economic operation of the LHD/SN, to oversight financial and operational performance and assure itself financial and performance reports provided to it are accurate.

To this end, the Board and Chief Executive attest that:

1) The financial reports submitted to the Finance & Performance Committee and the Ministry of Health represent SESLHD's financial position and the operational results fairly and accurately and are in accordance with generally accepted accounting principles
2) The recurrent budget allocations in the Ministry of Health's financial year advice align with those allocations distributed to SESLHD's units and cost centres.
3) It is assured overall financial performance is monitored and reported to the Finance and Performance Committee of SESLHD.
4) Information reported in the Ministry of Health monthly reports reconciles to and is

consistent with reports to the Finance and Performance Committee.

5) It is assured all relevant financial controls are in place except for Control deficiencies noted in the Audit Office NSW Management Letter.
6) Creditor levels conform to Ministry of Health requirements.
7) Write-offs of debtors have been approved by duly authorised delegated officers, as reported by the Director of Finance/Chief Financial Officer.
8) SESLHD's General Fund has exceeded the Ministry of Health approved the net cost of services allocation *(Please refer to item 5 in the qualification section for further details).*
9) It is assured SESLHD did not incur any unfunded liabilities during the financial year.
10) The Director of Finance has reviewed the internal liquidity management controls and practices and they meet Ministry of Health requirements.

The Internal Auditor has reviewed the above ten points during the financial year.

SESLHD complies with critical government policy directives and policies, including the Accounts and Audit Determination for Public Health Organisations, annual budget allocation advice, the Fees Procedure Manual, Goods and Services Procurement Policy and the Accounting Manual.

Service and Performance agreements

A written service agreement was in place during the financial year between the Board and the Secretary, NSW Health, and performance agreements between the Board and the Chief Executive, and the Chief Executive and all Health Executive Service Members employed within SESLHD.

The Board has mechanisms in place to monitor the progress of matters contained within the Service Agreement and to regularly review performance against agreements between the Board and the Chief Executive.

The Finance and Performance Committee

The Board has established a Finance and Performance Committee to assist the Board and the Chief Executive to ensure that the operating funds, capital works funds, resource utilisation and service outputs required of SESLHD are being managed in an appropriate and efficient manner.

During the financial year, the Finance and Performance Committee comprised the following membership:

- Jonathan Doy, Board Member (Chair)
- Patricia Azarias, Board Member
- Neville Mitchell, Board Member
- Michael Still, Board Chair

The Chief Executive attends all meetings of the Finance and Performance Committee unless on approved leave. The Committee met 10 times during this period.

The Finance and Performance Committee receives monthly reports that include:

- Financial performance of each major cost centre
- Liquidity management and performance
- The position of Special Purpose and Trust Funds
- Activity performance against indicators and targets in the performance agreement for SESLHD
- Advice on the achievement of strategic priorities identified in the performance agreement for SESLHD
- Year to date and end of year projections on capital works and private sector initiatives.

Letters to management from the Auditor-General, Minister for Health, and the NSW Ministry of Health relating to significant financial and performance matters are also tabled at the Finance and Performance Committee.

Standard 5: MAINTAINING HIGH STANDARDS OF PROFESSIONAL AND ETHICAL CONDUCT

The SESLHD has adopted the NSW Health Code of Conduct to guide all staff and contractors in professional conduct and ethical behaviour.

The Code of Conduct is distributed to, and signed by, all new staff and is included on the agenda of all staff induction programs. The Board has systems and processes in place to ensure the Code is periodically reinforced for all existing staff.

The Board and the Chief Executive lead by example in order to ensure an ethical and professional culture is embedded within SESLHD. Ethics education is also part of SESLHD's learning and development strategy.

The Chief Executive, as the Principal Officer for SESLHD, has reported all known cases of corrupt conduct, where there is a reasonable belief that corrupt conduct has occurred, to the Independent Commission Against Corruption, and has provided a copy of those reports to the Ministry of Health.

For the period SESLHD reported 11 cases of corrupt conduct.

Policies and procedures are in place to facilitate the reporting and management of public interest disclosures within SESLHD in accordance with state policy and legislation, including establishing reporting channels and evaluating the management of disclosures.

For the period SESLHD reported 7 of public interest disclosures.

All complaints about bullying, harassment, grievances and professional misconduct are treated seriously and managed in accordance with Legislation, NSW Health policies. Appropriate disciplinary actions are taken for all substantiated allegations.

Standard 6: INVOLVING STAKEHOLDERS IN DECISIONS THAT AFFECT THEM

The Board seeks the views of local providers and the local community on SESLHD plans and initiatives for providing health services and also provides advice to the community and local providers with information about the SESLHD plans, policies and initiatives.

SESLHD has a Community Partnerships Strategy which was endorsed by the board. It has since created a Community Partnerships portfolio which is responsible for providing leadership and coordinated support for giving our consumers, carers, volunteers and community members a stronger voice across SESLHD so we meet their needs now and into the future.

SESLHD is keen for community members to have more control over the decisions being made concerning their own health and wellbeing and to be involved in other activities to ensure accountability across the system.

A range of community participation and engagement approaches are used to maximize the opportunities for genuine engagement and consultation with our diverse community. For example, we have formed a District Community Partnership Committee, which reports to the Board. The purpose of this Committee is to ensure SESLHD has a coordinated and comprehensive approach to partnering and engaging with individuals, local communities and with external agencies.

Our hospitals and community health services also have local Community Advisory Committees.

These Committees include:

- Prince of Wales and Sydney/Sydney Eye Hospitals and Health Services
- Royal Hospital for Women
- St George Hospital and Health Services
- Sutherland Hospital and Health Services

A range of other community/stakeholder advisory committees are in place across SESLHD to provide local communities with a voice. These include, but are not limited to, people living with mental illness, hepatitis C and HIV, the Sydney Metropolitan Local Aboriginal Health Partnership and the Multicultural Health Stakeholder Advisory Committee.

SESLHD also administers grants through its Non-Government Organisation (NGO) Coordination Unit.

In addition, SESLHD has established a District Community and Consumer Council (CCC) to provide advice to SESLHD's peak committees on strategies and approaches to enhance and promote consumer, carer and community participation.

Information on the key policies, plans and initiatives of SESLHD and information on how to participate in their development are available to staff and the public at http://www.seslhd.health.nsw.gov.au/HealthPlans/default.asp

Standard 7: ESTABLISHING SOUND AUDIT AND RISK MANAGEMENT PRACTICES

Role of the Board in relation to audit and risk management

The Board supervises and monitors risk management by SESLHD, its facilities and units, including SESLHD's system of internal control. The Chief Executive develops and operates the risk management processes for SESLHD.

The Board receives and considers reports of the External and Internal Auditors for the SESLHD, and through the Audit and Risk Management Committee monitors their implementation.

The Chief Executive ensures that audit recommendations and recommendations from related external review bodies are implemented.

SESLHD uses the Enterprise Risk Management System (ERMS) to report and manage its risks. Responsible managers and staff are assigned in responding to risks and escalating these where appropriate. Risks in the ERMS are categorized according to the following areas:

- Leadership and management.
- Clinical care.
- Health of population.
- Finance.
- Fraud prevention.
- Information Management.
- Workforce.
- Security and safety.
- Facilities and asset management.
- Emergency and disaster planning.
- Community expectations.

A Risk Management Strategy 2018 – 2021 and Risk Management Work Plan 2018 – 2021 has been drafted and extensively consulted and updated through 2018-2019. The Strategy and Plan will be reviewed and further populated by the Chief Executive for endorsement in the new financial year (*Please refer to item 6 in the qualification section for further details*).

Audit and Risk Committee

The Board has established an Audit and Risk Committee, with the following core responsibilities:

- to assess and enhance SESLHD's corporate governance, including its systems of internal control, ethical conduct and probity, risk management, management information and internal audit
- to ensure that appropriate procedures and controls are implemented by management to provide reliability in SESLHD's financial reporting, safeguarding of assets, and compliance with SESLHD's responsibilities, regulatory requirements, policies and procedures

- to oversee and enhance the quality and effectiveness of SESLHD's internal audit function, providing a structured reporting line for the Internal Auditor and facilitating the maintenance of their independence through the internal audit function, to assist the Board to deliver SESLHD's outputs efficiently, effectively and economically, so as to obtain the best value for money and to optimize SESLHD's performance in terms of quality, quantity and timeliness; and
- to maintain a strong and candid relationship with external auditors, facilitating to the extent practicable, an integrated internal/external audit process that optimises benefits to the SESLHD and maintain a current Charter outlining its roles and responsibilities to SESLHD.

During 2018/19 the Audit and Risk Committee comprised of four members, three of which were independent members. The Chair and members of the Audit and Risk Committee are:

- Todd Davies, Independent Chair
- Jeanette Baker, Independent Member
- Patricia Azarias, Independent Board Member
- Robert Farnsworth, Board Member

The Audit and Risk Committee met on 6 occasions during the financial year.

Minutes from the Audit and Risk Committee are provided to the board to help inform the Board of the activities undertaken by Audit and Risk Committee during the course of the year and bring any matters that require the Board's attention.

The Audit and Risk Management Committee provides advice to the Chief Executive with respect to the financial reports submitted to the Finance and Performance Committee. The Chairperson of the Committee has right of access to the Secretary, NSW Health.

Qualifications to the governance attestation statement

Item 1: Authority and role or senior management

Qualification:

The "Delegations of Authority" manual requires updating to reflect the current SESLHD management structure.

Progress:

The Delegations manual has been reviewed and is currently in draft format. It will be presented to the Executive Council and the Board Finance & Performance sub-committee at the end of July 2019.

Remedial Action:

The "Delegations of Authority" manual will be finalised by the end of July 2019.

Item 2: Authority and role of senior management

Qualification:

Leadership and accountability responsibilities for Aboriginal health are not built into the roles of executives and managers at all levels within SESLHD as required under Section 2.2.1 of the NSW Health Corporate Governance Compendium.

Progress:

Workforce Services are in the process of reviewing position descriptions to ensure the promotion of Aboriginal health is addressed.

Remedial Action:

Workforce Services will update the position description template to include Aboriginal health leadership and accountability responsibilities and will encourage inclusion in future position descriptions of senior executives or managers at all levels within SESLHD.

Item 3: Regulatory responsibilities and compliance

Qualification:

SESLHD has developed appropriate Corporate Records Management policies to assist with compliance with the State Records Act (NSW) 1998 however, it is unlikely that SESLHD can attest to full compliance with in terms of Corporate Records Management. Given the definition of a corporate record is *"Recorded information, in any form, including data in computer systems, created or received and maintained by an organisation or person in the transaction of business or the conduct of affairs and kept as evidence of such activity"* there are many thousands of corporate records created each day.

This has been entered as a risk in the Enterprise Risk Management Systems.

Corporate Records Management within the Office of the Chief Executive is managed in line with the Act and relevant policies. However, SESLHD has a devolved system of Corporate Records Management. Each Tier 2 Director is assigned responsibility for records management within their Directorate.

Progress:

A Corporate Records Management Strategic Plan has been developed and approved.

A Corporate Records Management Framework has been approved.

Remedial Action:

Each Directorate has been provided with a template to assist with the formulation of a Corporate Records Management Operational Plan. The advice can be provided by the Records Management Coordinator within the Office of the Chief Executive.

Item 4: Regulatory responsibilities and compliance

Qualification:

SESLHD does not have a documented Corporate Governance Plan as required by Section 2.2.3 of the NSW Health Corporate Governance Compendium.

Progress:

Management is in the process of documenting the Corporate Governance arrangements in place that exist at a District and Facility/Directorate level to help inform the completion of the Corporate Governance Plan.

Remedial Action:

The Chief Executive has assigned responsibility for the development and implementation of a Corporate Governance Plan by 2019.

Item 5: Monitoring financial and service delivery performance

Qualification:

As at 30 June 2019, SESLHD reported an unfavourable General Fund Expense variance of $37.6m with a favourable variance to its General Fund revenue allocation of $1.8m which represents an overall unfavourable variance of approximately 2.32% to General Fund budget allocation.

Progress:

The District has initiated a series of projects to mitigate the variance to budget in 2019/20.

Remedial Action:

The District has revised its approach to budget allocation for 2019/20, ensuring that the staff establishment is reviewed and funding allocated accordingly. Efficiency targets have been allocated to the sites and services to assist in mitigating the variance to budget. Monthly reporting against efficiency targets will be provided to the Executive Finance and Performance meeting and the Board Finance and Performance sub-committee. In addition, the efficiency plans will be reviewed and monitored at the monthly performance meetings with the sites and services.

Item 6: Risk Management Plan

Qualification:

SESLHD has a current risk management plan. The plan covers all known risk areas including:

(a) Leadership and management
(b) Clinical care
(c) Health of population
(d) Finance [including fraud prevention]
(e) Information Management
(f) Workforce
(g) Security and safety
(h) Facilities and asset management
(i) Emergency and disaster planning
(j) Community expectations.

Progress:

A Risk Management Strategy 2018 – 2021 and Risk Management Work Plan 2018 – 2021 has been drafted and extensively consulted and updated through 2018-2019. Although still waiting endorsement, the Risk Management Unit has been executing on the Strategy / Plan deliverables and actions over the past 12 months. The Strategy and Plan will be reviewed and further populated by the Chief Executive for endorsement in the new financial year.

Remedial Action:

Chief Risk Officer to work with the Chief Executive to revise the Strategy and Plan for endorsement within the next 3 months.

Tobi Wilson-Chief Executive

Alan Ngo-Chief Audit Executive