T16/32807

Corporate Governance Attestation Statement for
South Eastern Sydney Local Health District
1 July 2015 - 30 June 2016

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 27 July 2016.

The Board is responsible for ensuring effective corporate governance frameworks are established for the South Eastern Sydney Local Health District. This statement sets out the main corporate governance frameworks and practices in operation within SESLHD for the 2015-2016 financial year.

A signed copy of this statement will be provided to the Ministry of Health.

Signed:

Michael Still
Chairperson

Date: 1 August 2016

Gerry Marr
Chief Executive

Date: 1 August 2016

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*.

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

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

Board meetings

For the 1 July 2015 – 30 June 2016 financial year the Board consisted of a Chair and twelve members appointed by the Minister for Health. The Board met eleven 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.

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

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.

A 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 NSW Health policy directive 'Patient Safety and Clinical Quality Program' (PD2005_608).

During 2015, SESLHD established a Board Health Care Quality Subcommittee 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 Health Care Quality Committee, as a Board Sub-committee, is responsible for 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.

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 clinical privileges of visiting practitioners or staff specialists.

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. It does so through delivery of the following core functions:

> National Standards and Accreditation

> Incidents and Complaints (IIMS)

> Clinical Performance

> Hand Hygiene

> Root Cause Analysis (RCA)

> SAC 2 Incident Management

> Quality Systems Assessment (QSA)

> Clinical Practice Improvement

> Safety Alerts and Product Recalls

> Open Disclosure

> Improvement and Innovation Awards

B SETTING THE STRATEGIC DIRECTION FOR SESLHD AND ITS SERVICES

The Board has in place strategic plans for the effective planning and delivery of its services to the communities and individuals served by SESLHD. This process includes setting a strategic direction for both SESLHD and the services it provides.

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

a Asset management
b Information management and technology
c Research and teaching
d Workforce development
e Integrated Care Strategy
f Health Services Strategy
g Equity Strategy
h Community Partnerships Strategy

The strategic priorities for SESLHD have been documented in its 2012-2017 strategy document which is supported by the SESLHD's Roadmap to Excellence 2014 -2017 that sets out a new and accelerated focus on a number of priority areas for action to create a higher performing, equitable and sustainable health system. The Roadmap is underpinned by the Triple Aim framework which was developed by the Institute of Healthcare Improvement. The framework, which has three dimensions: quality of care, health of the population and value and financial sustainability. The Road Map describes the priority areas for action with clearly assigned responsibility for delivery.

C 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 ensures that the financial and performance reports provided to the Board and those submitted to SESLHD's Finance and Performance Committee and the Ministry of Health are accurate and that relevant internal controls for SESLHD are in place.

The Board has approved, and has in place systems to support the efficient and economic operation of SESLHD, 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 certify that

- The financial reports submitted to the Finance & Performance Committee and the Ministry of Health represent a true and fair view, in all material respects, of SESLHD's financial condition and the operational results are in accordance with the relevant accounting standards
- The recurrent budget allocations in the Ministry of Health's financial year advice reconcile to those allocations distributed to organisation units and cost centres.
- Overall financial performance is monitored and reported to the Finance and Performance Committee of SESLHD.
- Information reported in the Ministry of Health monthly reports reconciles to and is consistent with reports to the Finance and Performance Committee.
- All relevant financial controls are in place.
- Creditor levels comply with Ministry of Health requirements.
- Write-offs of debtors have been approved by duly authorised delegated officers.
- SESLHD's General Fund has not exceeded the MOH approved net cost of services allocation.
- SESLHD did not incur any unfunded liabilities during the financial year.
- The Director of Finance has reviewed the internal liquidity management controls and practices and they comply with Ministry of Health requirements.

The Internal Auditor reviews the above on a regular and planned basis.

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 ensure that the operating funds, capital works funds and service outputs required of SESLHD are being managed in an appropriate and efficient manner.

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

- Ms Kate Munnings (Chair)
- Michael Still (Board Chair)
- Ms Kristin Stubbins (Advisor)
- Ms Patricia Azarias (Board Member)
- Mr Jonathon Doy (Board Member from January 2015)

- Mr Gerry Marr (Chief Executive)
- Mr Mark Shepherd (Director of Programs and Performance)
- Ms Karen Foldi (Director of Finance)
- Mr George Deletaris (Director of Internal Audit from April 2016)

The Chief Executive attends all meetings of the Finance and Performance Committee unless on approved leave.

The Finance and Performance Committee receives monthly reports that include:

- Financial performance of each major cost centre
- Liquidity 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.

D MAINTAINING HIGH STANDARDS OF PROFESSIONAL AND ETHICAL CONDUCT

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

The Code of Conduct is distributed to 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. 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.

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.

E INVOLVING STAKEHOLDERS IN DECISIONS THAT AFFECT THEM

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

South Eastern Sydney Local Health District (SESLHD) has a strong commitment to involving community members (consumers, carers, volunteers, the broader community and agencies) in the planning, co-design, delivery and evaluation of our services and programs.

During 2015/16 SESLHD developed a Community Partnerships Strategy which was endorsed by the board in late 2015. 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 the organisation 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 ensure accountability across the system.

A range of community participation and engagement approaches are used to maximise 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 our organisation 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 the organisation to provide local communities with a voice. These include, but are not limited to, people living with mental illness, hepatitis C and HIV, and 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 2015/16 approximately 49 grants were provided to NGOs within the Local Health District with the aim of improving the health and wellbeing of people in the community.

In addition, SESLHD is currently establishing a Consumer and Community Council (CCC) to provide advice to the organisation'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 to the public at http://www.seslhd.health.nsw.gov.au/HealthPlans/default.asp

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

To support good governance practices and achieve the operational independence of the internal audit function, the SESLHD Chief Audit Executive has a dual reporting line. A dual reporting line means that the Chief Audit Executive:

- Reports administratively to the Chief Executive to facilitate day-to-day operations of the internal audit function; and
- Reports functionally to the Audit and Risk Committee for strategic direction and accountability of the internal audit function.

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

SESLHD has a current Risk Management Plan. The Plan covers all known risk areas including:

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

Audit and Risk Management Committee

The Board has established an Audit and Risk Management 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 in place 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 best value for money and to optimise organisational 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 SESLHD.

During 2015/16 the Audit and Risk Management Committee comprised five members, four of which were independent members. The Chairperson of the Audit and Risk Management Committee is Mr Todd Davies who is one of the independent members of the committee. The other members of the committee are Mr Jim Mitchell (independent, term to 30 June 2016), Ms Lyn Baker (independent), Ms Patricia Azarias (independent Board member), and Dr Robert Farnsworth (Board member). The Audit and Risk Management Committee met on seven occasions during the financial year.

The Chairperson of the committee has right of access to the Secretary of the NSW Ministry of Health.

G QUALIFICATIONS TO GOVERNANCE ATTESTATION STATEMENT

Item: Monitoring financial and service delivery performance

SESLHD's General Fund exceeded the MOH approved Net Cost of Services (NCOS) allocation.

Qualification
SESLHD achieved an unfavourable General Fund NCOS result for 2015/16 of $11.9M. It should be noted that this result excluded additional cash assistance of $35.5M received from the Ministry of Health. No budget adjustment to revenue was received resulting in an overall favourable result for the District.

Progress
The District has initiated strategies to ensure it meets budget in 2016/17.

Remedial Action
The District has continued to implement Value Improvement Plans (VIP's) covering both expenditure and revenue to address the unfavourable result. In particular, detailed recovery plans have been developed by the Sites and services to realign their costs to budget.

The Program Management Office has provided savings targets to all sites and/or services and is supporting the finalisation and oversight of VIP's for 2016/17.

Detailed reports on achievement of the strategies outlined within the recovery plans have been developed and are tabled for inclusion in the monthly performance meetings as well as the Board meetings for 2016/17.

Item: Mechanisms are in place to ensure that relevant legislation, regulations and relevant government policies and NSW Health policy directives are adhered to, including statutory reporting requirements.

Qualification

It is unlikely that SESLHD can attest to full compliance with the *State Records Act (NSW) 1998* in terms of Corporate Records Management. Under the *State Records Act 1998*, *each public office must establish and maintain a records management program for the public office in conformity with standards and codes of best practice from time to time approved under section 13. (Section 12(2).* 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. Many of these records are saved in email folders, share point, share drives, desk tops and removable media devices. None of these methods of storage are compliant with Digital Recordkeeping Standards, they do not classify the record, assign a retention schedule or record sufficient meta data.

Progress

A Corporate Records Management Committee has been established and meetings have commenced.

A Corporate Records Management Strategic Plan has been developed and approved by the committee and Executive Sponsor.

A Corporate Records Management Framework has been drafted and is currently open for comment and feedback.

Remedial Action

The Committee consider and Implement a SESLHD Corporate Records Management Strategic Plan 2015 – 2020.

In conjunction with iiHUB Corporate Records Management Committee to develop a training and education program for staff and include records management as part of mandatory orientation.

Director of Programs in conjunction with Director of Finance make provision for a separate identifiable budget for Corporate Records Management Program for the 2016/2017 FY and beyond.

Mr Gerry Marr, ***Chief Executive***

George Deletaris, ***Director of Internal Audit***