NSW GOVERNMENT Health

Illawarra Shoalhaven Local Health District

Corporate Governance Attestation Statement

2018 - 2019

CORPORATE GOVERNANCE ATTESTATION STATEMENT ILLAWARRA SHOALHAVEN LOCAL HEALTH DISTRICT

The following corporate governance attestation statement was endorsed by a resolution of the Illawarra Shoalhaven Local Health District Board at its meeting on 5 August 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 Illawarra Shoalhaven 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 Organisation for the 2018-2019 financial year.

This attestation statement has been reviewed by Internal Audit to ensure the Local Health District (LHD) 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:

Professor Denis King OAM
Chairperson

5 August 2019
Date

Ms Margot Mains
Chief Executive

5 August 2019
Date

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 Organisation 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 Chair Professor Denis King OAM and 12 members appointed by the Minister for Health. The Board met 11 times during this period. Of these, five were formal Board meetings.

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 the Organisation.

The roles and responsibilities of the Chief Executive and other senior management within the Organisation 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 the Organisation, including statutory reporting requirements.

The Board has mechanisms in place to gain reasonable assurance that the Organisation 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.

Whilst governance structures are in place to monitor compliance with legislation, policies and procedures, the LHD is in the process of developing its own formal compliance framework to enhance the transparency of its compliance with legislative requirements.

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 the Organisation 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). 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 Health Care Quality Committee, Clinical Governance Council and a Strategic Executive Committee are established to provide the Board and the Chief Executive with assurance and advice on clinical matters affecting the LHD.

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.

An Aboriginal Health Partnership Committee is established, or clear lines of accountability are in place for clinical services delivered to Aboriginal people.

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 the Organisation.

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

The Board has in place strategic plans, such as the 'Local Health Services Plan 2012-2022' and the 'Strategic Directions for Illawarra Shoalhaven Local Health District 2017 - 2020', for the effective planning and delivery of its services to the communities and individuals served by the Organisation. This process includes setting a strategic direction for both the Organisation and the services it provides within the overarching goals and priorities of the NSW State Health Plan.

Organisation-wide planning processes and documentation is also in place, with a three to five year horizon, covering:

a Asset management – Designing and building future-focused infrastructure
b Information management and technology – Enabling eHealth
c Research and teaching – Supporting and harnessing research and innovation
d Workforce development – Supporting and developing our workforce
e Aboriginal Health Action Plan – Ensuring health needs are met competently

These plans have been cascaded through the Organisation in a structured approach through the commencement of major initiatives such as:

- The Asset Strategic Plan 2018-2028
- The ICT Strategic plan 2016 – 2021
- Research & Innovation Strategy 2017-2020
- Strategic Directions for Illawarra Shoalhaven Local Health District - 2017 - 2020
- The Strategic Capability Development Program
- ISLHD's Workforce Planning Framework
- The Financial Sustainability Program
- The Aboriginal Mental Health action plan
- Closing the Gap - Aboriginal Health Action Plan 2017-2020

Standard 4: MONITORING FINANCIAL AND SERVICE DELIVERY PERFORMANCE

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

The Organisation 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 Finance and Workforce Performance Committee and the Ministry of Health, and that relevant internal controls for the Organisation are in place to recognise, understand and manage its exposure to financial risk.

The Board has confirmed that the Organisation has in place systems to support the efficient, effective and economic operation of the LHD, 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 and Workforce Performance Committee and the Ministry of Health represent the Organisation'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 Organisation units and cost centres.
3. It is assured overall financial performance is monitored and reported to the Finance and Workforce Performance Committee of the Organisation.
4. Information reported in the Ministry of Health monthly reports reconciles to and is consistent with reports to the Finance and Workforce Performance Committee.
5. It is assured all relevant financial controls are in place.
6. Creditor levels conform to Ministry of Health requirements. At times during the year some creditors were paid outside of payment terms and exceed Ministry's timeframes (45 days) however they were not significant in volume or value.
7. Write-offs of debtors have been approved by duly authorised delegated officers, as reported by the Executive Director Finance.
8. The Public Health Organisation General Fund **has** exceeded the Ministry of Health approved net cost of services allocation, as stated in the Organisation's
9. Service Agreement. (See qualification commentary)
10. It is assured the Organisation did not incur any unfunded liabilities during the financial year.
11. The Executive Director 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.

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 the Organisation.

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 Workforce Performance Committee

The Board has established a Finance and Workforce 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 the Organisation are being managed in an appropriate and efficient manner.

The Finance and Workforce Performance Committee is chaired by Board member Mr Paul Knight and comprises of three other Board members:

- Professor Denis King OAM - Board Chair
- Ms Evelyn Bosak - Board Member (from 1 January 2019)
- Mr Alan Hudson - Board Member (from 1 January 2019)

Dr Stephen Anderson OAM also sat on the Committee until leaving the Board on 31 December 2018.

The Chief Executive is represented at all meetings of the Finance and Workforce Performance Committee by the Executive Director Finance, and the Executive Director Strategic Improvement Projects. The Director of Internal Audit is also an attendee.

The Finance and Workforce Performance Committee has an agreed annual schedule of meetings and work program. This schedule is part of the governance calendar for the full Board, with regular reporting going from the Committee to the Board.

The Committee met 11 times during this period.

The Finance and Workforce 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 the Organisation
- Advice on the achievement of strategic priorities identified in the performance agreement for the Organisation

- 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 tabled at the Audit and Risk Committee and the Board. The Finance and Workforce Performance Committee were briefed on the content and process for finalising the Auditor-General's report to management.

Standard 5: MAINTAINING HIGH STANDARDS OF PROFESSIONAL AND ETHICAL CONDUCT

The LHD 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 the Organisation. Ethics education is also part of the Organisation's learning and development strategy. The LHD has developed a 'Corporate Governance Hub' intranet site to guide staff on ethical issues including Conflicts of Interests, Gifts and Benefits and Fraud and Corruption.

The Chief Executive, as the Principal Officer for the Organisation, 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, the Organisation reported 29 cases of suspected corrupt conduct, a number of these related to suspected misuse of information. The Organisation has a zero tolerance of misuse of information and routinely undertakes reviews to identify instances where this may have occurred and make the required reports to the Independent Commission Against Corruption and the Ministry of Health.

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

For the period the Organisation reported 13 public interest disclosures.

Standard 6: INVOLVING STAKEHOLDERS IN DECISIONS THAT AFFECT THEM

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

Processes have been implemented within the LHD to better engage with and respond to the identified needs of our consumers. The District has commenced implementation of its newly developed 'Partnering with Consumers Framework' that enables meaningful, relevant and consistent engagement with patients, carers and other consumers across the LHD. The Framework will include a process for the recruitment of consumers to committees and other decision-making groups including the ISLHD Clinical Governance Council.

The 'Health Provider and Partnership Network', (formerly the Health Co-Design Council) the group is a forum for engaging local providers and their clients in service delivery. It assists the Organisation in accessing networks of consumers from a variety of backgrounds and abilities. This group consists of representatives from the local primary health network, aged care, multicultural services, mental health, children and families, youth, heart health, healthy cities and cancer services.

Examples of the District engaging consumers and service providers in strategic initiatives include involvement in: the Fit for Frailty Program (aimed at improving the outcomes and experience of frail older consumers and their carers) and the Bulli Aged Care Centre development.

The Aboriginal Health Partnership Agreement has been established with the ISLHD Chief Executive as the Co-Chair of the Committee that meets quarterly. There are Local Partnership Agreements are in place with:

- South Coast Aboriginal Service,
- Oolong House Drug and Alcohol Rehabilitation Centre,
- Illawarra Aboriginal Medical Service,
- Waminda South Coast Women's Health and Welfare
- Aboriginal Corporation,
- University of Wollongong,
- South East NSW Primary Health Network.

All ISLHD's key policies, are available to staff on the ISLHD Intranet Site: http://islhnweb/. There are well established processes in place for staff to be involved in the development of policies and initiatives of the Organisation.

ISLHD has commenced an upgrade of its internet platform to develop a more responsive, robust and user-friendly public website which includes the Organisation's plans, initiatives and how to participate in their development. Processes are underway to create a public policy page on the new internet with information provided so consumers can view and access the Organisation's local policies as well as participate in their development. ISLHD's Intranet site is http://www.islhd.health.nsw.gov.au.

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 the Organisation and its facilities and units, including the Organisation's system of internal control. The Chief Executive develops and operates the risk management processes for the Organisation.

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

The Chief Executive ensures that audit recommendations and recommendations from related external review bodies are implemented. The Board, through the Audit and Risk Committee, monitors the implementation of these recommendations.

The Organisation has a current Enterprise Risk Management Strategic Plan encompassing both clinical and non-clinical risks. The Plan covers all known risk areas including:

- 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.

Audit and Risk Committee

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

- to assess and enhance the Organisation'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 the Organisation's financial reporting, safeguarding of assets, and compliance with the Organisation's responsibilities, regulatory requirements, policies and procedures
- to oversee and enhance the quality and effectiveness of the Organisation'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 the Organisation'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 the Organisation.
- to maintain a current Charter outlining its roles and responsibilities to the Organisation.

The above core responsibilities are embedded in the Audit and Risk Committee's Charter.

The Audit and Risk Committee reviews the monthly narrative financial reports submitted to the Finance and Workforce Performance Committee and provides advice to the Chief Executive with respect to the Annual Financial Statements which are also submitted to the Finance and Workforce Performance Committee.

The Audit and Risk Committee met six times during the financial year and the Chairperson of the Committee has right of access to the Secretary, NSW Health.

Qualifications to the governance attestation statement

Item 1 - Qualification - Section 4: Monitoring Financial and Service Delivery Performance:

Noting the current Service Agreement, through end of financial year (EOFY) June 2019, the District had a 1.6 per cent unfavourable variance to budget for Expenses and 4.6 per cent favourable variance for Own Source Revenue. These results are reported to the Ministry every month and discussed with them including at the Ministry Performance Meetings.

As a result, the District has exceeded the EOFY June 2019 general fund net cost of services budget for 2018/19 by $6.0 million (unaudited).

As a result of the above the Board and the Chief Executive are unable to certify that:

- ISLHD's General Fund has not exceeded the Ministry approved net cost of services allocation.

Progress:

The District has an unfavourable variance to budget which is reported to the Ministry and discussed with the Ministry including at the Ministry Performance Meetings. A key driver of this variance being the additional activity undertaken above the activity allocated in the funding budget. The District has developed a number of strategies to align financial performance with budget expectations.

Remedial Action:

The District has established a Savings and Efficiency (SEG) group comprising the CE, Core Executive and other Senior Management. Their charter is to identify and implement savings opportunities across the District.

The Organisation also has the 'Financial Sustainability Program' operating which was established to achieve financial stability and sustainability into the future as an essential platform for ongoing service delivery.

Signed:

Angela Butler
Senior Corporate Governance Co-ordinator

6/8/19.
Date

Gordana Trajcevski
Chief Audit Executive

12/8/19.
Date

Margot Mains
Chief Executive

5/8/19
Date