Integration Joint Board
Audit and Risk Committee

9 September 2019

This Report relates to
Item 6 on the Agenda

Internal Audit Annual Report

(Paper presented by Julie Watters)

For Discussion and Noting

Approved for Submission by	Chief Finance Officer, Integration Joint Board
Author	Julie Watters Chief Internal Auditor Integration Joint Board
List of Background Papers	
Appendices	**Appendix 1** - NHS Annual Internal Audit report 2018/19 **Appendix 2** - NHS Final Governance Statement 2018/19 **Appendix 3** – Dumfries and Galloway Council Annual Internal Audit report 2018/19 **Appendix 4** - Dumfries and Galloway Draft Governance Statement 2018/19

SECTION 1: REPORT CONTENT

Title/Subject: IJB Internal Audit Annual Report

Meeting: Audit and Risk Committee

Date: 9 September 2019

Submitted By: Julie Watters

Action: For Discussion and Noting

1. Introduction

1.1 The purpose of this report is to update Audit and Risk Committee on the assurances gained from delivery of the Internal Audit Plan for the Integration Joint Board (IJB) for the year 2018/19.

2. Recommendations

2.1 **The IJB Audit and Risk Committee is asked to note the contents of this report which summarises the work undertaken by Internal Audit during 2018/19 and provides the Chief Internal Auditor's opinion on the internal control environment within the Integration Joint Board for the financial year 2018/19.**

Chief Internal Auditor's opinion on the System of Internal Control 2018/19

This statement is provided for the use of Dumfries and Galloway Integration Joint Board in support of the Governance Statement for the year ended 31 March 2019.

Based on our work throughout the year, Internal Audit have concluded that:
- There were adequate and effective internal controls in place throughout the year;
- The Accountable Officer has implemented a governance framework in line with required guidance sufficient to discharge the responsibilities of this role;

In addition, we have not advised of any concerns around the following:
- The format and content of the Governance Statement in relation to the relevant guidance
- The process adopted in reviewing the effectiveness of the system of internal control and how these are reflected
- Consistency of the Governance Statement with the information that we are aware of from our work
- The disclosure of relevant issues

The 2018/19 Internal Audit plan has been delivered in line with the Public Sector Internal Audit Standards.

3. Background

3.1 The Scottish Government Integrated Resources Advisory Group (IRAG) issued "Guidance for Integrated Financial Assurance" in support of the Public Bodies (Joint Working) (Scotland) Act 2014.

3.2 The guidance requires the Integration Joint Board (IJB) to establish adequate and proportionate internal audit arrangements for the review of risk management, governance and control of the delegated resources. The guidance further states that the IJB has a responsibility for reviewing the effectiveness of the governance arrangements including the system of internal control.

3.3 Internal Audit is required to provide an annual assurance statement on the overall adequacy and effectiveness of the framework of governance, risk management and control to inform the above review and the preparation of the governance statement.

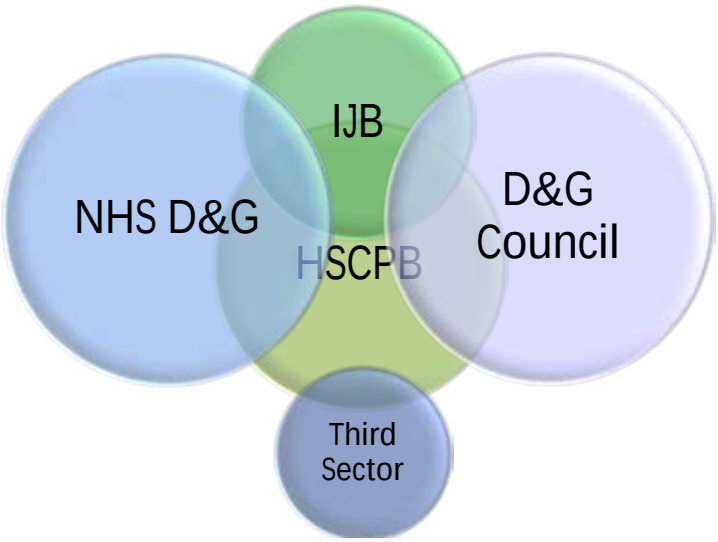
3.4 The internal audit plan for the IJB for 2018/19 has taken into consideration the operational delivery of services within the Health Board and Local Authority on behalf of the IJB and the assurances that have been delivered by the separate internal audit plans completed during 2018/19.

4. Main Body of the Report

Audit Plan – Delivery of assurances

4.1 As approved by Audit and Risk Committee, the audit plan for 2018/19 has been structured to address the requirements at this stage in the integration process and recognises that assurances required are changing as the maturity of the IJB develops.

4.2 Audit assurances to the IJB are not delivered in isolation and the internal audit functions of both the NHS and Council also deliver assurances to their own organisations that should also be considered by the IJB where relevant. The following diagram gives a simplistic demonstration of the overlap in assurances and responsibilities, although in reality the boundaries are not as clear cut as the diagram indicates.



4.3 As Chief Internal Auditor, consideration of all assurances has been undertaken to provide an annual assurance statement which considers the whole control environment in which the IJB operates and this annual report to the IJB provides my opinion on the IJB's internal control framework for the financial year 2018/19.

4.4 No IJB specific internal audit reviews have been undertaken during the course of the year, however audit work carried out within each of the host organisations has been considered in preparing this annual report.

NHS Dumfries and Galloway – Assurances considered

4.5 During 2018/19 the NHS Internal Audit function delivered the following audits, many of which have also been considered in forming an overall opinion on the control environment of the IJB.

Audit	Assurance	Number of actions	IJB relevance
Delegated Authorities	Moderate	12	ü
Contract Management	WIP	-	ü
Transport	Moderate	11	ü
IT Security	WIP	-	
Digital Health Strategy	Moderate	4	ü
Waste Management	Moderate	10	
Recruitment and Retention - Staff Turnover	WIP	-	ü
Patient Access and Waiting Times	Moderate	6	ü
Services for Older People	Significant	3	ü
Hospital Cleaning	Significant	5	ü
Adverse Incident Reporting	Significant	7	
Property Transaction Monitoring	Comprehensive	-	
Capital Assets	Significant	4	
Payroll	Significant	2	
Equipment Bank	Significant	6	ü

4.6 All of these audits give an indication on the control environment within the IJB to some extent given that staffing and processes that sit within the NHS are delivering on the objectives of the IJB, however those with more relevance have been identified above. This information was reported to the Health Board's Audit and Risk Committee in June 2019 in the NHS Internal Audit Annual Report which is attached at **Appendix 1** for information.

4.7 The Delegated Authorities audit had 12 recommendations, 4 of which are relevant to the IJB. These relate to

- The IJB Scheme of Delegation
- An Agenda Matrix for all the IJB committee business
- A tracking mechanism for receipt of all standing committee minutes, and
- The creation of an assurance map for the IJB

4.8 Updates on the progress of these actions will be brought back to future Audit and Risk Committee meetings.

4.9 The Health Board has a robust process for preparing the Governance Statement which collates assurances from across the relevant areas of governance. This statement has been reviewed along with supporting evidence **(Appendix 2)**.

Dumfries and Galloway Council – Assurances considered

4.10 The Chief Internal Auditor of the IJB has discussed with the Internal Audit Manager of Dumfries and Galloway Council assurances that can be gained from work they have undertaken that could be relevant to the IJB. Whether or not audits are directly IJB related, audits undertaken by DGC should be considered as they provide assurances over the control framework of the Council and have an impact where these areas come under the remit of the IJB either partly or indirectly.

4.11 The Annual Report of the Council's Chief Internal Audit Manager which includes his Controls Assurance Statement is included at **Appendix 3**. This report details completion of the audit plan against what was proposed and details staffing pressures within the Internal Audit team due to staff secondment which reduced the number of audit days delivered. No audits were undertaken within the Council that had direct relevance to the IJB.

4.12 Moving forward, days have been allowed from the Council plan to cover IJB audit work and it would be expected that these would be recorded in the annual report and assurances of this work shared with the Council's Audit, Risk and Scrutiny Committee.

4.13 A further assurance that was requested this year from the Council's Internal Audit Manager was a formal summary of work undertaken within the Council. A verbal update was given and no issues were raised.

4.14 The Council's draft Governance Statement **(Appendix 4)** has also been considered to understand where assurances are given relating to integration and joint working.

Similar to last year's statement this makes specific reference to strengthening Elected Members' and Officers' understanding of IJB governance arrangements and roles and responsibilities which was identified as an area for development for 2018/19 and again for 2019/20.

Assurances specific to the Integration Joint Board

4.15 There have been a number of meetings between the Chair and Vice Chair of the IJB Audit and Risk Committee and the Chief Internal Auditors of both the Council and the NHS Board to refine the process for sharing assurances and understand the relationship between the control environments of the respective host organisations and the overall assurance framework within the IJB.

4.16 During 2016/17, one audit was undertaken which was specific to the IJB, IJB/01/17 - IJB Governance Arrangements. This audit gave a Moderate level of assurance and had 9 recommendations. Of the 9 recommendations made, 7 have formally been closed off with 2 still outstanding. The table below details the Management Action Plan from this audit detailing the background to these actions.

	Audit Findings and Recommendations		**Management Response**
No	**Key Risk / Control weakness**	**Recommendation**	**Management Action**
5	**Finding Group: Governance** **Finding Type: Capacity to Deliver** There is a risk that assurances are not being delivered to the appropriate forum where committee business has not been aligned between the IJB and the NHS. This also poses a risk of duplication.	**Grade – C** The IJB and NHS committees should be reviewed and their roles aligned to ensure that the appropriate information is being reported to the appropriate forum in accordance with the delegation of functions. It must also be ensured that while agendas may be amended, that assurance mechanisms are established to ensure the necessary feedback to partner agencies as set out by the Integration Scheme.	A review of governance arrangements is planned, which will include a review of both the NHS and IJB Committees to streamline processes to ensure effective use of each committee going forward. **Evidence required:** We would expect to see the Terms of Reference of committees within the revised structure clearly detail the role and remit of each committee and assurances to be delivered. **Manager Responsible** Julie White **Target Date** 31st March 2018
9	**Finding Group: Risk Management** **Finding Type: Monitoring** There is a risk that risk management monitoring arrangements are not actioned as described by the Risk Management Strategy. This arises following a discrepancy in what has been set out and that discussed at H&SCSMT for exception reporting.	**Grade – C** It must be ensured that the risk management monitoring arrangements stipulated by the Risk Management Strategy are implemented as described or the necessary amendments made to reflect how assurances are intended to be delivered in practice.	Paper to be presented to IJB Audit and Risk Committee in September providing information on corporate risk register and ongoing plans to develop risk. **Evidence required:** We need confirmation and evidence that the Risk Management processes detailed within the Risk Strategy are being followed. This is not currently in place **Manager Responsible** Maureen Stevenson/ Richard Fox **Target Date**

	Audit Findings and Recommendations		Management Response
No	**Key Risk / Control weakness**	**Recommendation**	**Management Action**
			31st December 2017

4.17 The first of these relates to the governance arrangements for the IJB and in order to close this we would require to see clearer reporting between the IJB's committees and those of the Council and Health board and that this is fully supported within all their relevant Terms of Reference. The second of these actions relates to the risk management strategy for the IJB and its implementation. Audit and Risk Committee are fully sighted on the issues surrounding risk management at this time and risk remains an active agenda item moving forward.

SECTION 2: COMPLIANCE WITH GOVERNANCE STANDARDS

5. Resource Implications

5.1 As the NHS and Council audit plans for 2018/19 had already been approved and internal resources committed to their delivery, the IJB work was undertaken internally from the existing resource within the NHS Internal Audit function.

5.2 For 2019/20 resources have been identified from within the Health and local authority internal audit functions which will work towards an audit

6. Impact on Integration Joint Board Outcomes, Priorities and Policy

6.1 Internal Audit is a key element of the delivery of independent assurances around the achievement of the IJB's objectives.

7. Legal & Risk Implications

7.1 There are a number of limitations to the audit plan delivered in that the risk register for the IJB was not available to inform the plan and ensure that it is based on management's view of risk. This is an area that is being enhanced for the future.

8. Consultation

8.1 The IJB Chief Finance Officer and Chair of the Audit and Risk Committee were consulted on the proposed audit plan and its delivery. The yearend reporting process has been discussed with the committee Chair and Vice Chair.

9. Equality and Human Rights Impact Assessment

9.1 The Equality Framework within NHS D&G has been considered in creating the audit plan. An equalities impact assessment has not been completed.

10. Glossary

10.1. The following details the abbreviations and associated terms encountered throughout the course of this report.

Abbreviation	Term
D&GC	Dumfries and Galloway Council
IJB	Integration Joint Board
IRAG	Integrated Resources Advisory Group
NHS D&G	NHS Dumfries and Galloway
PSIAS	Public Sector Internal Audit Standards

Agenda Item 1

DUMFRIES and GALLOWAY NHS BOARD

AUDIT and RISK COMMITTEE

17th June 2019

Annual Internal Audit Report 2018/19

Author:
Julie Watters
Chief Internal Auditor

Sponsoring Director:
Jeff Ace
Chief Executive

Date: 4th June 2019

RECOMMENDATION

Audit and Risk Committee is asked to **discuss and note** the contents of this report which summarises the work undertaken by Internal Audit during 2018/19 and provides an opinion on the internal control environment within the Board.

CONTEXT

Strategy/Policy:

The Chief Internal Auditor's Annual Statement of Assurance, as required for the Governance Statement, is attached in **Appendix 3**.

Organisational Context/Why is this paper important/Key messages:

This Annual Report presented to Audit and Risk Committee provides an overview of the outcomes of the 2018/19 Internal Audit Plan and highlights the Chief Internal Auditor's opinion on the adequacy and effectiveness of the Board's internal control framework, risk management and governance processes.

GLOSSARY OF TERMS

Datix	-	Board's Risk Management system
EQA	-	External Quality Assessment
SFI's	-	Standing Financial Instructions

MONITORING FORM

Policy / Strategy Implications	This paper is part of the overall Internal Audit reporting framework where assurance is provided to the Board through Audit and Risk Committee.
Staffing Implications	None
Financial Implications	None
Consultation / Consideration	None
Risk Assessment	Internal Audit work is undertaken within a risk-based auditing framework. Internal Audit risks are assessed and contained within the Internal Audit risk register on Datix.
Risk Appetite	Low [X] Medium [ ] High [ ] In the absence of an appetite statement in relation to governance ad compliance with board policy this is deemed to be low in that this is a key part of the boards control framework and essential to the workings of Audit and Risk Committee.
Sustainability	Sustainability is considered within the Audit Planning process.
Compliance with Corporate Objectives	The Internal Audit plan is informed by all NHS Dumfries and Galloway's corporate objectives and considers the risks that may impact on their achievement.
Local Outcomes Improvement Plan (LOIP)	Whilst considered, not directly relevant to this paper
Best Value	All Best Value themes are considered through the annual audit plan, however this paper gives specific consideration to: · Vision and Leadership, · Governance and Accountability, · Performance Management, and · Sustainability
Impact Assessment Whilst a full impact assessment has not been undertaken, Equality and Diversity issues are fully considered during the audit planning process.	

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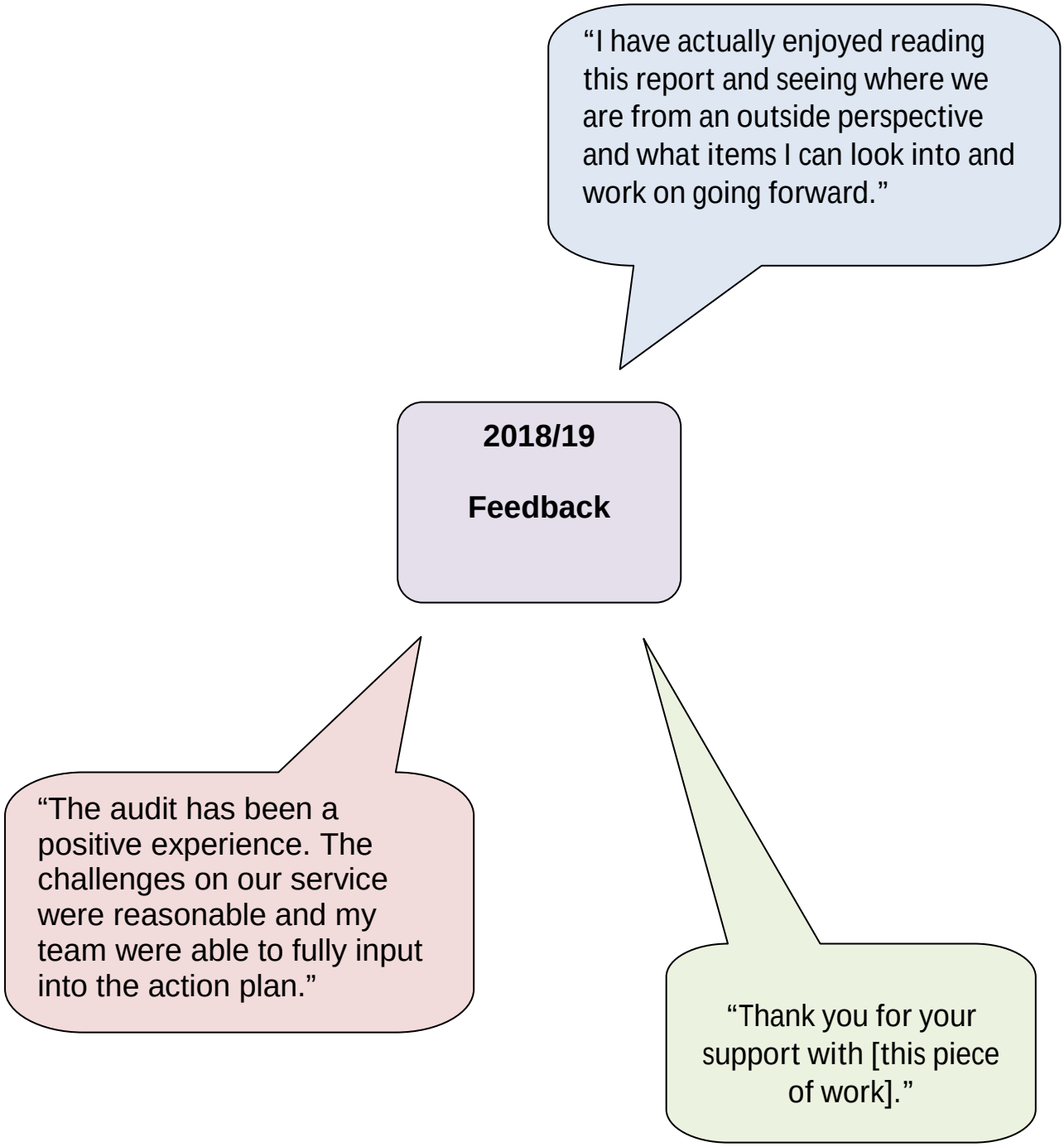

"I have actually enjoyed reading this report and seeing where we are from an outside perspective and what items I can look into and work on going forward."
2018/19
Feedback
"The audit has been a positive experience. The challenges on our service were reasonable and my team were able to fully input into the action plan."
"Thank you for your support with [this piece of work]."

1. INTRODUCTION

1.1 Introduction

This Annual Report presented to Audit and Risk Committee provides a formal overview of delivery against the 2018/19 Internal Audit Plan and details other work undertaken within the Audit department during the course of the year. This report also provides the Chief Internal Auditor's opinion on the adequacy and effectiveness of the Board's internal control framework, risk management and governance processes for the financial year 2018/19.

This report has been structured to:

- Summarise assurances gained from the 2018/19 audit plan,
- Draw attention to areas of particular relevance through audit opinions and assurances gained,
- Summarise Internal Audit activity for 2018/19 and include performance indicators, and
- Provide the Chief Internal Auditor's Annual Statement of Assurance – **Appendix 3**.

1.2 Background

Internal Audit is an independent, objective assurance and consulting activity designed to add value and improve the Board's operations. It helps the Board to accomplish its objectives by bringing a systematic, disciplined approach to evaluating and improving the effectiveness of risk management, control and governance processes.

The range of Internal Audit activity covers the whole network of the Board's systems and the internal controls established to:

- Achieve the Board's objectives
- Ensure the economical and efficient use of resources
- Ensure compliance with established policies, procedure, laws and regulations
- Safeguard the Board's assets and interests from losses of all kinds including those arising from fraud, irregularity or corruption
- Ensure the integrity and reliability of information and data.

Executive Directors and Senior Management are responsible for ensuring that internal control arrangements are sufficient to address the risks facing their service areas and Internal Audit assesses the adequacy of, and provides assurance on, these arrangements.

The Chief Internal Auditor is responsible for the production of a risk based Annual Audit Plan, which is structured to ensure that the highest risk areas of the Board are audited within acceptable timescales, by audit resources appropriate to enable adequate assurances to be provided to Audit and Risk Committee.

1.3 Role of Internal Audit

The purpose, authority and responsibilities of the Internal Audit function within NHS Dumfries and Galloway are set out in the Internal Audit Charter and the Board's Standing Financial Instructions.

The Audit Charter was revised and presented to Audit and Risk Committee in March 2018 along with the 2018/19 Audit Plan. The Charter included minor revisions made to ensure that it reflects all current audit guidance and gives due consideration to the Public Sector Internal

Audit Standards. The Charter was further revised as part of the 2019/20 Audit Plan as the Board's Standing Financial Instructions had been amended with the Internal Audit section being removed. All relevant information has been included in the Internal Audit Charter.

The Statement of Assurance provides an overview of the work undertaken during the course of the year and the assurances that can be taken from our audit work by the Chief Executive as Accountable Officer and our External Auditors.

2. ASSURANCE REPORT

2.1 Audit Plan 2018/19

The Internal Audit Plan for 2018/19 was approved at Audit and Risk Committee in March 2018.

The plan was structured to cover key areas and processes to provide assurance on what were assessed to be the highest priority areas of risk within the Board and to support the assurances required at the year-end for the Governance Statement.

The format of the plan is largely similar to that of the previous year which was intended to provide assurance on processes, with testing being undertaken across larger samples within the Board. This is felt to be a more effective use of audit days with more meaningful information coming through in the audit reporting.

During 2018/19, Internal Audit have completed 8 planned audits to reporting stage. The remainder of the audits have commenced with scopes drawn up, commencement meetings with managers and testing being undertaken. This has not flagged up any issues for management or the Accountable Officer to be aware of, despite the fact that the reports have not been prepared.

These audits will be reported in the coming months as management are available to debrief on findings. There is an allowance within the 2019/20 Audit Plan for carry forward audits.

All of the audits completed have been used to inform the Chief Internal Auditor's Statement of Assurance and are summarised in the table in **Appendix 1**.

2.2 Assurances gained from Audit work

Assurances given are based on a number of different elements to form an opinion on the assurance level, but ultimately any assurance given is evidence based. Where a test cannot be carried out or where evidence cannot be provided then formal assurance cannot be given that satisfactory controls or processes are in place to support the achievement of objectives within a given area.

The table in **Appendix 1** at the end of the report expands on this by mapping the audits against the Best Value characteristics and the four main strands of Governance to enable this information to be used to inform the Statement of Assurance and to provide information on where independent assurance has been gained across these areas.

The assurances from the various audits are summarised in the table below.

Table 1 – Assurances on audit work

Audit title	Assurance level			
	Limited	Moderate	Significant	Comprehensive
Delegated Authorities		t		
Contract Management				
Transport			t	
IT Security				
Digital Health				
Recruitment and Retention - Staff Turnover				
Waste Management			t	
Patient Access and Waiting Times				
Services for Older People				
Hospital Cleaning				t
Equipment Bank				
Adverse Incident Reporting			t	
Property Transaction Monitoring				t
Capital Assets				t
Payroll			t	

Overall, the 2018/19 audit plan has delivered mixed levels of assurances. One audit has given Comprehensive Assurance (1 in 2017/18), four audits have given a Significant level of assurance (5 in 2017/18) and three audits have given Moderate Assurance (6 in 2017/18). We can confirm that there have been no Limited Assurance audits during 2018/19 compared to two in 2017/18.

2.3 Reporting to Audit and Risk Committee

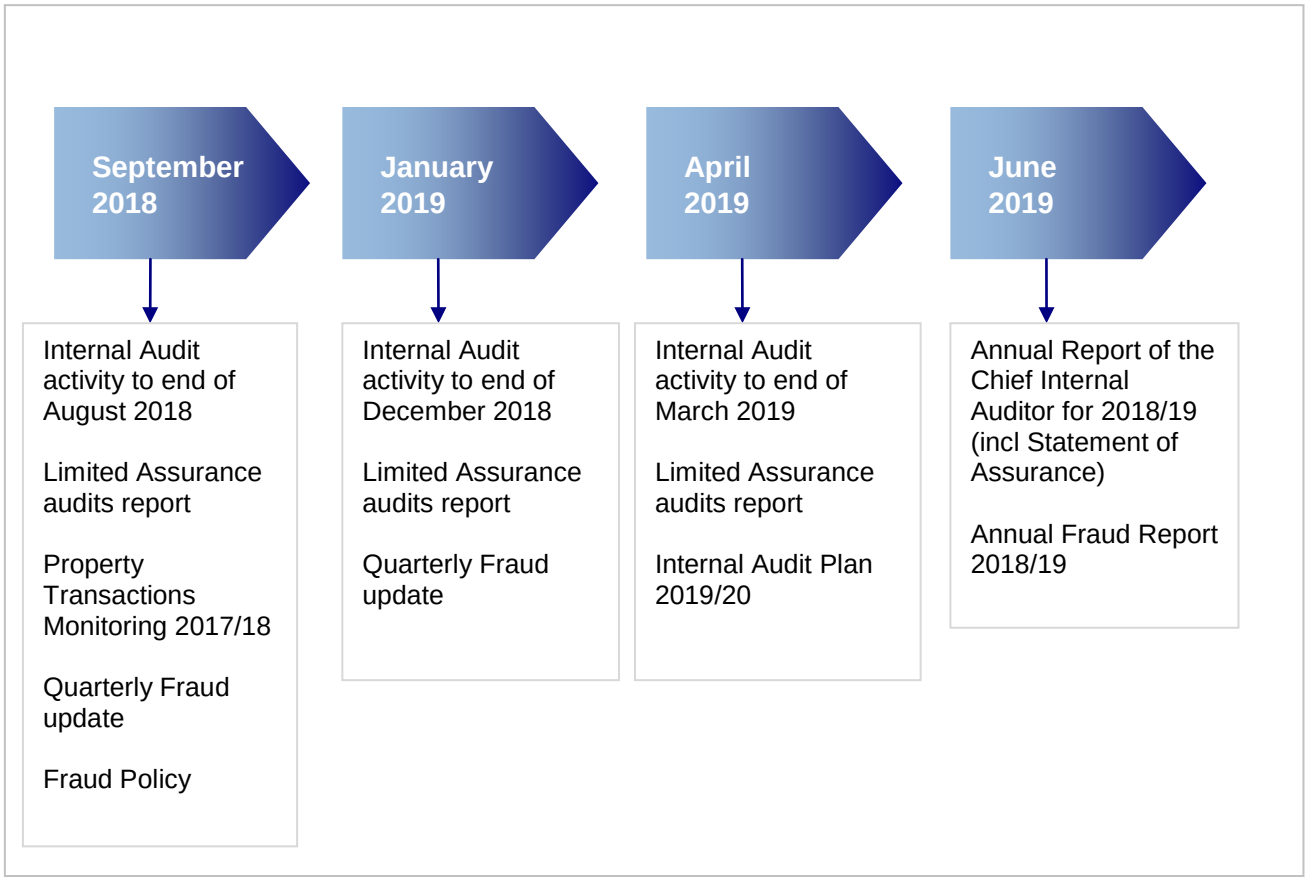
In addition to Audit and Fraud reporting, Intelligence Alerts from Counter Fraud Services are also brought to each Audit and Risk Committee as they are issued. These are detailed in the Annual Fraud report.

Specific Limited Assurance audit reports are brought to Audit and Risk Committee as they are issued so that committee are made aware of specific weaknesses in the area that has been reviewed.

Limited Assurance audits now remain a standing item on the Audit and Risk Committee agenda to ensure that the continued focus on the closure of audit actions will not allow these audits to lose visibility and to ensure that committee members have the opportunity to receive updates on progress against these audits.

During 2018/19 the following reports were brought to Audit and Risk Committee by the Chief Internal Auditor.

Figure 2 – Reporting to Audit and Risk Committee – 2018/19



The Chief Internal Auditor brings forward areas of concern during the year and historically closure of audit actions has been identified as an area that will require further scrutiny.

During the course of audits, the audit team are having some very challenging conversations with managers in relation to the areas of Risk Management, Business Continuity and the board's policy framework. Managers feel they are being singled out when they are being questioned about what they do in these areas and feel they do not have appropriate guidance. There is a lack of awareness or understanding of these critical areas of board governance. Internal Audit will continue to raise the profile of these areas but unless there is a change of focus within the board we will continue to receive negative feedback which given the national recognition of the importance of governance in the NHS is not acceptable moving forward.

3. PERFORMANCE REPORT

3.1 Performance Management

Internal Audit have a range of key performance indicators within the section. These indicators are intended to measure internal performance and also measure those external factors that may impact on our delivery of the audit plan. The balanced scorecard approach which has been adopted provides a rounded set of measures that provide information to track performance throughout the year.

These performance indicators are subject to ongoing review and are used to inform the function's quality assurance and improvement processes. This information was of particular use when the audit function went through an External Quality Assessment (EQA) process a couple of years ago. One of the actions was to enhance the KPI's with the involvement of Audit and Risk Committee which incorporated the Chief Internal Auditors objective setting process to ensure that a top down approach was adopted.

3.2 Audit Activity

The audit team continue to use AutoAudit, an audit software system, which was introduced during 2012/13. The functionality of the system has been developed to dovetail with existing audit processes. This is ongoing and as audit practices evolve the system is reviewed to ensure that it supports these. The system has built in flexibility which helps the team to reflect changes in audit practice and update the system with emerging risks.

At key stages in each audit we have taken the opportunity to move from paper based to software hosted processes. This has been tested as we have gone along to ensure that the functionality of the system is operating as would be expected.

The audit plan for 2018/19 carried 305 audit days.

During the year 226.13 audit days were undertaken by the audit team. This is broken down as follows

- 186.97 days against the 2018/19 plan (including time delivering on the IJB audit)
- 39.17 days closing off audits from the 2017/18 plan

This shortfall in audit days (78.87) coincides with a vacancy within the audit section which left a gap of 16 weeks (80 days)

Audit work for the Integration Joint Board has been undertaken from within the existing NHS resource. The assurances provided from all audit work undertaken are considered both within a Health Board and IJB context. This decision has been endorsed by the Director of Finance and Chief Executive with assurances from all audit work for 2018/19 to be shared with both IJB and NHS Audit and Risk Committees.

The Internal Audit function has suffered a number of resource pressures during the course of the year with a staff vacancy and unexpected leave of absence.

Due to these staffing pressures an assurance checklist was created and sent to the key contacts for all the audits scheduled for the year to complete by way of a self assessment against the areas identified. These were returned and have been used to prioritise the higher risk areas within the plan through the management responses received.

The focus of the section in the last two months of the audit year has been completion of the audit plan which has left very little capacity for any additional elements other than the continued follow-up work required to close off audit actions. 8 audits from the 2018/19 audit plan having been completed to reporting stage.

The two main elements of non-audit time are Audit Development & Administration (47.20 days) and Corporate Support (35.37 days) with Follow up recording 19.80 days.

Time recorded against Audit Development & Administration includes, for example, ongoing maintenance of our audit system, review of working documents and maintenance of our Internal Audit intranet page. This is therefore time spent by the audit team on non-audit specific tasks. Administration time has increased due to a change in administrative support. Auditors had to pick up this work whilst there was a vacancy in this role last year and used this as an opportunity to overhaul the teams' admin processes. There is an aim to reduce this time next year.

There has been a continued focus this year in getting responses to outstanding actions on Issue Track. This requires review of every response that comes through on the system and verification that the evidence provided has met the requirements of the initial recommendation. Follow up time is similar to last year, although audit have been asked to review management responses in a number of spreadsheets that have been brought back to Audit and Risk Committee. This time has been recorded against Corporate Support as this has been limited to a review of updated information with no evidence provided and therefore no opportunity to close the actions off.

Corporate Support currently stands at 35.37 days this year. Time allocated against this includes attending meetings such as Information Assurance Committee, fire officer duties, support to staff on completing their actions within Issue Track and dealing with ad hoc requests for support. This has increased this year as a great deal of support has been given to managers to close off a number of historic actions. As this increases this will impact on audit plan delivery, therefore will need to be reduced this coming year.

Internal Audit's full KPIs are detailed in **Appendix 2**. This is for transparency to inform committee members of range of indicators that can be used, although these have not been actively measured during the course of the year. These will be fully reported on during the course of the 2019/20 audit year.

3.3 Reporting to Management

The outcomes of all audits are reported to relevant local managers, Audit and Risk Committee, the Chief Executive (Accountable Officer) and External Audit. A series of recommendations to remedy any control weaknesses or risks are identified in the Management Action Plan at the end of the audit report, to which a response is given by management in the form of an agreed action to meet the requirements of the recommendation.

For every recommendation that is made there has been a risk or control weakness identified which, until remedied by management remains an outstanding risk to the Board or may open up the system which has been audited to abuse or manipulation. It is therefore a crucial element of the audit process that timely responses to all recommendations made are identified and passed back to Internal Audit so that the audit report can be finalised and issued to the Accountable Officer and our External Auditors.

3.4 Audit Follow-Up Processes

As previously mentioned, all recommendations are input into the AutoAudit software system as reports are issued. As audits are undertaken the risks, controls, findings, actions and subsequent management update are recorded on the system.

By using AutoAudit and the webhosted section Issue Track, we can facilitate the management update of any outstanding issues and subsequent internal audit verification of the implementation of agreed action points.

These processes do not detract from the assurances gained from the confirmation provided by management to the Chief Executive updating on the implementation of agreed recommendations. This is a valuable part of the assurance process whereby managers are informing the Chief Executive as Accountable Officer directly of their progress on recommendations.

The monitoring of the implementation of audit recommendations is an area that is under continuing review to ensure that the processes for collation of, and the mechanism for reporting on progress against, recommendations is as efficient as possible. Auditors currently monitor progress against each recommendation and identify whether the action is complete or whether there is a requirement for further testing.

Information within the system can be accessed at any time which allows for real time monitoring of progress against identified risks. The most recent position as at 3rd June 2019 is detailed below.

Table 3 – Audit actions by Director

Director	Total	Overdue	Open	Pending Review	Closed
Katy Lewis	135	9	5	0	121
Julie White	114	4	8	0	102
Eddie Docherty	53	16	0	0	37
Jeff Ace	99	0	1	0	98
Caroline Sharp	48	0	8	0	40
Dr. Ken Donaldson	6	0	0	0	6
Michele McCoy	3	0	0	0	3
Grand Total	**458**	**29**	**22**	**0**	**407**

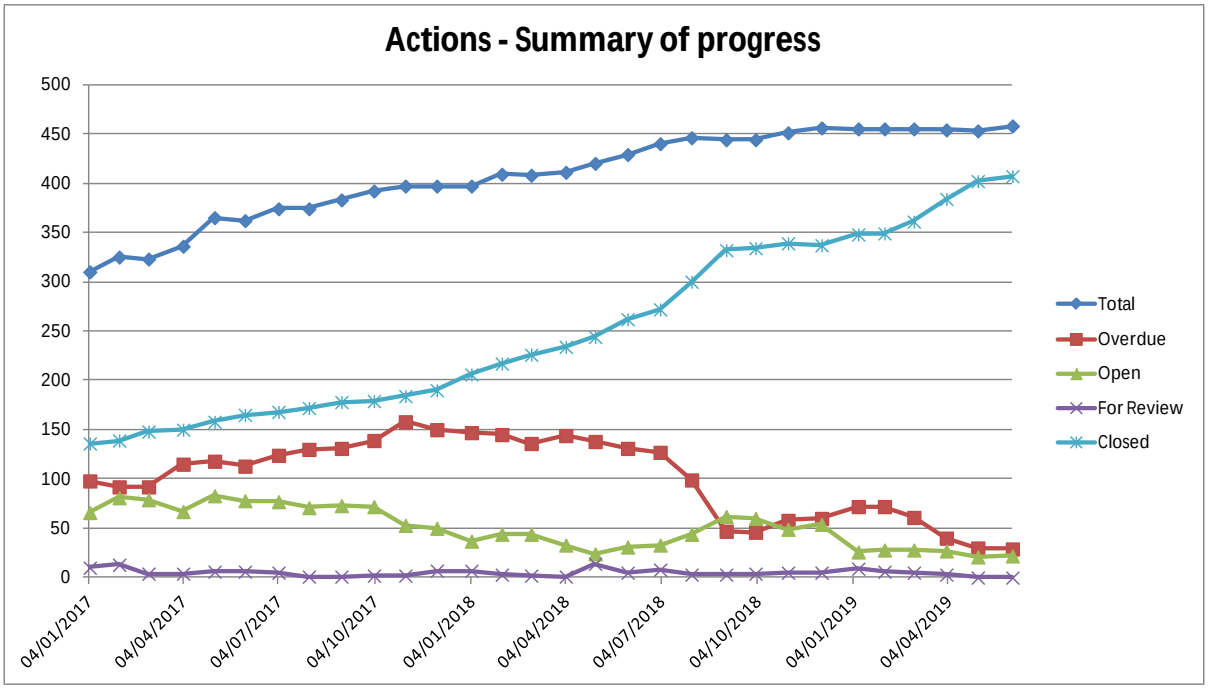
The numbers of overdue actions at the last three year-ends is detailed below as a comparison.

- June 2016 – 105
- June 2017 – 113
- June 2018 – 131
- June 2019 – 29

This drop in overdue actions has been due to a concerted effort on the part of management to clear these. This gives the opportunity for management to review their actions and to determine if these are still relevant and current. None have been closed due to being

irrelevant or obsolete. Management continue to recognise that these should be actioned and have detailed their responses accordingly.

Figure 4



We can see that the number of overdue actions has dropped and this should be recognised as a significant improvement on previous years.

It should be ensured by management that this focus continues and this is not seen as a one off exercise. Whilst there has been an improvement in understanding of the governance aspects to closing off actions, there is still a requirement to develop understanding across the board in relation to governance, risk management and internal controls.

Information on progress against outstanding actions will continue to be reported to Audit and Risk Committee and Management Team to allow improvement measures to continue as required.

4. SUMMARY

Many improvements have been introduced within Internal Audit to ensure better working practices are adopted and to ensure that appropriate professional standards are adhered to. This requires consolidation to ensure that the assurances gained from audit work undertaken reflect the professionalism and effectiveness of the section.

The Statement of Assurance in **Appendix 3** provides more detailed information on audit assurances as they relate to the specific areas within the Governance Statement.

5. ACKNOWLEDGEMENTS

I would like to take this opportunity to thank all members of staff within the Board for the help and co-operation extended to Internal Audit and to thank the audit team and administrative support for their continuing commitment and effort during the course of the year.

Audit Plan 2018/19 – Progress and Outcomes

Best Value							Governance									
Vision and Leadership	Governance and Accountability	Use of Resources	Performance Management	Effective Partnerships	Equality	Sustainability	Financial	Staff	Clinical	Information			Status	Recommendations A	B	C	D	Total	Assurance
ü	ü	ü	ü	ü	ü	ü	ü	ü	ü	ü	A/01/19	Delegated Authorities	Prelim	-	8	4	-	12	Moderate
ü	ü	ü	ü		ü	ü	ü	ü	ü	ü	A/02/19	Contract Management	-	-	-	-	-	-	-
	ü	ü	ü	ü		ü	ü	ü			A/03/19	Transport	Prelim	2	5	4	-	11	Moderate
ü	ü	ü	ü	ü	ü	ü	ü		ü	ü	A/04/19	IT Security	-	-	-	-	-	-	-
		ü	ü	ü	ü	ü	ü	ü	ü	ü	A/05/19	Digital Health	-	-	-	-	-	-	-
	ü	ü	ü	ü		ü		ü	ü		A/06/19	Waste Management	Final	-	4	6	-	10	Moderate
	ü	ü	ü	ü	ü	ü	ü	ü		ü	A/07/19	Recruitment and Retention - Staff Turnover	-	-	-	-	-	-	-
	ü	ü	ü	ü		ü	ü		ü	ü	A/08/19	Patient Access and Waiting Times	-	-	-	-	-	-	-
ü	ü	ü		ü	ü				ü	ü	A/09/19	Services for Older People	-	-	-	-	-	-	-
ü		ü	ü	ü	ü		ü	ü	ü		A/10/19	Hospital Cleaning	Prelim	-	2	3	-	5	Significant
								ü	ü	ü	A/11/19	Adverse Incident Reporting	Final	3	3	1	-	7	Significant
	ü	ü	ü	ü	ü	ü		ü	ü	ü	F/01/19	Property Transaction Monitoring	Final	-	-	-	-	0	Comprehensive
	ü	ü			ü	ü	ü		ü	ü	TS/01/19	Capital Assets	Final	-	2	2	-	4	Significant
	ü	ü	ü	ü	ü	ü	ü	ü	ü	ü	TS/10/19	Payroll	Prelim						Significant
	ü	ü	ü			ü	ü		ü	ü	TS/18/19	Equipment Bank	-	-	-	-	-	-	-
																		49	

Internal Audit Performance Measures – KPI's

Goals	Cost, Quality, Delivery	Measures	KPI
Stakeholder perspective To assist the board through the enhancement of working practices and system/process controls.	Q	Recommendations accepted	95% of audit recommendations to be accepted
	Q	Timely closure of audit issues	
	Q	Audit feedback requested from management on issue of final reports detailing satisfaction measures and feedback.	To increase to at least 50% return rate
Internal Business perspective Operate an efficient and effective service through the timely provision of internal audit deliverables.	D	Percentage of audit plan complete	To be within 10% of budget
	D	Audit days – Budget v Actual *based on finalised audits	To be within 10% of budget
Continuous Improvement perspective Maintain an appropriately qualified and experienced Internal Audit resource that meets relevant standards	Q	Conduct an annual self assessment of IA compliance against PSIAS	Completed during each audit year
	Q	Personal development reviews completed within timescales	100% completed within last 12 months
Financial perspective To utilise resources in the most efficient and effective manner.	C	To deliver the audit plan for year within the budget allocated	To be within 10% of budget

Annual Statement of Assurance from the Chief Internal Auditor 2018/19

Chief Internal Auditor's opinion of the System of Internal Control for 2018/19

This statement is provided for the use of NHS Dumfries and Galloway in support of the Governance Statement for the year ended 31 March 2019.

Based on our work throughout the year, Internal Audit have concluded that:

- There were adequate and effective internal controls in place throughout the year, and
- The Accountable Officer has implemented a governance framework in line with required guidance sufficient to discharge the responsibilities of this role.

In addition, we have not advised of any concerns around the following:

- The format and content of the Governance Statement in relation to the relevant guidance,
- The process adopted in reviewing the effectiveness of the system of internal control and how these are reflected,
- Consistency of the Governance Statement with the information that we are aware of from our work, or
- The disclosure of relevant issues

The 2018/19 Internal Audit plan has been delivered in line with the Public Sector Internal Audit Standards.

1. INTRODUCTION

This Annual Statement of Assurance has been created to formally document and communicate the Chief Internal Auditor's opinion on the adequacy and effectiveness of the Board's internal control framework for the financial year 2018/19.

This Statement should be read in conjunction with the other information received, as outlined in the Governance Statement guidance to support the Accountable Officer and Audit and Risk Committee's conclusions on the adequacy and effectiveness of internal controls.

2. BACKGROUND

The Chief Internal Auditor is required to give an annual opinion to the Board through the Audit and Risk Committee, on the adequacy and effectiveness of the internal control system within the Board and the extent to which it can be relied on.

As the Board's Accountable Officer, the Chief Executive is required to sign a Governance Statement for inclusion within the Annual Accounts.

The report of the Chief Internal Auditor is a key element of the independent assurance that is included in the overall framework of assurance and evidence of compliance that should be considered within the Governance Statement.

3. THE GOVERNANCE STATEMENT

The purpose of good governance within any organisation is to ensure that the level of direction and management of the affairs of the organisation is sufficient to align corporate behaviours with the expectations of the public and to be accountable to all stakeholders in the public interest. The process of governance involves the clear identification of responsibilities, accountabilities and adequate systems of supervision, control and communication.

As Accountable Officers, Chief Executives have a responsibility for maintaining a sound system of internal control and must prepare a Governance Statement that is accurate, complete and fairly reports the known facts.

Over a number of years there have been changes to the year-end governance reporting requirements which has seen a move from the original Statement of Financial Controls to the Statement on Internal Control and, most recently, the Governance Statement. This has been driven by a number of factors such as significant corporate collapses and major governance failings, which has led to the development of the UK Corporate Governance Code.

The issuing of guidance by the Scottish Government each year is seen as a cumulative process with Boards building on the strengths of the implementation of previous years' guidance and further developing processes to evidence compliance against the various aspects of governance. The most recent guidance within the online section of the Scottish Public Finance Manual (SPFM) summarises a range of assurances necessary to support the statement to ensure they are from a wide range of sources within NHS Boards. Whilst not being prescriptive on the format of the Governance Statement, the guidance details essential features for inclusion within the statement and draws Accountable Officer attention to the four governance strands of Clinical, Staff, Financial and Information Governance.

Audit Scotland completed a piece of work around good practice in preparing Governance Statements in May 2016 to help boards improve the disclosures made within their governance statements and ensure that they comply with the requirements of the SPFM. This guidance has been used by the board for a couple of years to develop the quality of our statement moving forward.

The Board has produced a Governance Statement which does not identify any disclosures.

My evaluation of the Chief Executive's compliance with Accountable Officer requirements and of the Board's Governance Statement draws on:

- the results of individual audits conducted during the year,
- assurances from Board officers, and
- official, relevant Board documentation presented as part of the preparation process for the Governance Statement

The process for collation of information to support the Governance Statement for 2018/19 has been supported with the production of a portfolio of documentation which informs the Accountable Officer and the Audit and Risk Committee on the information that is used to evidence the Governance Statement. This information is being made available in hard copy for all Board members to access and they will be able to raise any queries on the content with key officers who will be able to respond around the assurances provided in their area.

With the aim of providing a more focussed structure, Executive Directors were asked to consider a checklist covering key areas required to inform the Governance Statement in

relation to their particular areas of responsibility. These returns have been completed with varying levels of content and the shorter returns show no evidence of background information relied upon for completion.

The robustness of this process is unclear where the returns do not capture supporting information. The returns that I have been able to consider against internal audit findings are those that capture an enhanced level of detail.

In previous years a template was used which maintained a consistency in the format and content of the returns as well as ensuring that all the key governance and accountability areas were covered. This could be reintroduced for future years to enhance the level of reporting.

During the year we completed an audit on Delegated Authorities, covering the Scheme of Delegation, committee structures and reporting framework. This audit gave a Moderate level of assurance with 12 recommendations being made to improve NHS Board and IJB governance processes.

In previous audits we have made recommendations around the approval process for annual reports that we are placing reliance on for yearend processes i.e. Risk Management and Information Assurance. These reports should be approved through their respective groups/committees before being passed for assurance purposes. This has been taken on board by these groups and this should continue to be monitored to ensure the tight timescales for approval are met.

4. AUDIT ASSURANCES TO SUPPORT THE GOVERNANCE STATEMENT

The Chief Internal Auditor must prepare an Annual Statement of Assurance which provides an opinion on the adequacy and effectiveness of the Board's internal control framework, risk management and governance processes for the financial year 2018/19.

This Statement is prepared based on audit work undertaken and takes into account Director and Committee returns along with the annual Risk Management and Information Governance reports.

The Chief Internal Auditor is satisfied that the level of audit coverage over the year has provided a breadth of assurances from which to inform her audit opinion.

As each audit is undertaken, the results are reviewed by the Chief Internal Auditor and the areas of Governance and Best Value that each audit can provide assurance on are noted. This is then mapped into the year-end report which is presented to Audit and Risk Committee.

Audit work which can be identified as evidence in the various governance strands is detailed below along with specific information which has been drawn from the Directors' returns and Committee Assurance statements.

The Committee Assurance Statements follow the same template and cover areas such as membership, quoracy, attendance and minute approval through Board. There is a comments section which has been used in a range of ways by the respective committee chairs to capture information. The level of detail in these areas varies considerably with some much shorter than others.

Board Governance Framework

- **Staff Governance**

  The Workforce Director's assurance return offers examples of arrangements or processes that have been put in place during the course of the year to enable her to discharge her responsibilities as Workforce Director and links these with the corporate risks that she has lead responsibility for.

  The return mentions specific challenges in relation to Recruitment and Workforce Sustainability, Health and Safety, Workforce reporting systems (eESS) and equal pay claims

  The majority of our audits are focussed around processes and not departments or locations therefore there have been a number of audits such as that of Delegated Authorities and the New Hospital Migration and Commissioning audits that have considered, and provided assurances around, Staff Governance processes.

  Follow up work has been undertaken on a number of audits from previous years. The Workforce Director has monthly meetings with Internal Audit to look at progress against closing off outstanding actions. There are no overdue actions within the Workforce Director's area which is a significant improvement. 8 currently have a future due date. The Workforce Director meets monthly with Internal Audit to discuss progress on implementing actions and evidence that will be required to close these off.

- **Financial Governance**

  The Director of Finance's return refers to board's statutory and financial duties and the delegated areas of responsibility in relation to the system of internal control.

  The return goes on to summarise the various processes around which financial assurances are given.

  Audit testing of the key financial systems and processes within NHS Dumfries and Galloway is a significant element of the information that is required to inform the Financial Governance strand within the Statement of Assurance. Audits that have been undertaken in the last year have included:

  - Capital Assets - Significant Assurance
  - Payroll - Significant Assurance

  Follow up has also concluded or is well progressed on a number of audits with a large number of actions being closed during the course of the year. There are currently 9 outstanding actions out of the 14 that are currently open within this area. This is an improvement on previous years and reflects the work that has been done in this area.

  During 2018/19 we identified no significant weaknesses in the financial control systems we reviewed which would lead to those systems being open to significant abuse or error.

Through implementation of recommendations on previous audits, we are continuing to see more documented procedures and guidance to support the various roles and responsibilities covering financial processes.

- **Clinical Governance**

Clinical Governance is specifically covered within the Healthcare Governance Committee statement. The main focus of the work of the committee, when looking at the schedule of business for the year, is Patient Safety, Quality Improvement, feedback from various external performance reviews and learning from adverse incidents. This is consistent with previous years.

Assurance is also provided from the Nurse Directors statement which covers, amongst others, clinical governance, quality of care, risk management and patient safety. The Medical Director's statement is brief and confirms controls are in place but does not detail what evidence has been used to support this.

Within the Nursing Directorate there are currently 16 open actions, all of which are overdue. These cover a range of audits but relate mostly to Risk Management, Child Protection and Adverse Event Reporting. There needs to be a focussed effort to close these off and further reports will be brought back to Audit and Risk Committee on progress against these.

- **Information Governance**

Information to inform the Governance Statement in this area comes from the Information Assurance Committee (IAC) annual report.

The Information Assurance Committee (IAC) annual report details that there is a comprehensive governance structure in relation to assurances delivered around Information Governance. This report was not taken to Information Assurance Committee for approval prior to submission, however has been circulated around the members of the committee for feedback and approval. The format and content of this report appears more detailed than in previous years and reflects ongoing improvements in this area.

The Medical Director's role as Senior Information Risk Owner (SIRO) has not been recognised in the director's return.

We are undertaking two audits specific to Information Assurance:

- Information Governance and Security Improvement Measures – Limited Assurance

This audit aimed to provide assurance that we are implementing guidance in this area and that we have a strong and robust governance framework in place. We were unable to evidence this.

This Limited Assurance audit will be brought back to Audit and Risk Committee in full to discuss how gaps in this area can be resolved.

I can also call upon testing from other audits which have considered information systems and security. Our audit approach is to look at whole processes and this

has also looked to gain assurance from the IT systems being used and the levels of control that these offer.

In the past five years we have also undertaken the following audits:

- Information Governance – Moderate Assurance,
- Records Management – Moderate Assurance, and
- Data Protection – Moderate Assurance.

Historically, within the areas of Information Governance and Records Management there have been significant gaps in compliance and without the actioning of audit recommendations there were a number of very high risks that we have not been able to evidence that we are managing. This is an area that has improved in year as actions have been closed. It must be ensured that this focus remains to close off actions or to understand why they remain open and ensure that this reporting is taken through the Information Assurance Committee.

A great deal of support has been provided by Internal Audit to enable closure of actions. Many of these actions could have been implemented a number of years ago, and have only been taken forward with increased scrutiny on information governance and records management. With the improvements in the workings of the Information Assurance Committee this momentum should continue

- **Best Value**

How the board achieves Best Value is not detailed in the directors' or committee returns and therefore cannot be evidenced through this process.

As with the various governance strands, each audit undertaken is mapped against the principles of Best Value, therefore we build up a picture of where our work provides assurance on these principles. Therefore it can be demonstrated that Best Value is considered at the audit plan approval stage, during the course of each audit and at year-end with this Statement of Assurance.

- **Risk Management**

Three of the returns received from Directors refer to Risk Management in general terms and give various examples to evidence this. The return from the Workforce Director provides an overview of the corporate risks that she is responsible for and the return from the Nurse Director identifies that he has Executive responsibility for Risk.

There is a requirement for an Annual Risk Management report to be prepared. This should include a thorough description of how risk management has been embedded across the organisation. We can confirm that the Board has produced an Annual Risk Management report for this year which includes a number of areas that are to be taken forward in the 2019/20 financial year.

Risk continues to be governed through the Risk Executive Group and Risk Steering Group with minutes coming to Audit and Risk Committee for information.

The Corporate Risk Register has been revised in year and this is being linked into a Board Assurance Map. The setting of a Board Risk Appetite has been completed although there is little evidence of this being embedded across the

organisation. This is at early stages but understanding of what this is and how it can be used is not evidence below Board level.

Taking all the information contained within the portfolio of evidence into account I am satisfied with the consistency of the evidence which supports the Governance Statement with the information available from the work undertaken within Internal Audit.

5. BASIS OF ASSURANCE

Our opinion is limited to the work carried out by Internal Audit during the year based on the coverage of the Audit Plan. While all risks and areas of governance may not have been included in the 2018/19 Plan, we have undertaken sufficient work to provide reasonable assurance that there is an adequate control environment in place.

Our external auditors, Grant Thornton UK LLP, consider the work of internal audit as part of their audit process although they no longer require to place reliance on the work undertaken.

Audit and Risk Committee receive quarterly reports on the outcomes of audits undertaken and are able to request further information as required to enable them to form an opinion on assurances gained through the work of Internal Audit.

We have conducted our audits in accordance with the relevant mandatory Internal Audit Standards in place for NHSScotland during the course of the year. The relevant Standards for 2018/19 are the Public Sector Internal Audit Standards (PSIAS). These were adopted from 1st April 2013 to promote further improvement in the professionalism, quality and effectiveness of Internal Audit and reaffirm the importance of independent and objective internal audit arrangements to provide the Accountable Officer with key assurances needed to support the Governance Statement.

Guidance advises that minor deviations from the PSIAS should be reported to Audit and Risk Committee and more significant deviations should be considered for inclusion in the Governance Statement, with appropriate justification. Some issues which have previously been reported to Audit and Risk Committee have been addressed, such as the completion of an External Quality Assessment which supports the quality assurance and improvement processes within the function.

The external assessment carried out by KPMG and completed in November 2016 determined that the Internal Audit function conforms to PSIAS, and demonstrates several areas of good practice and effective corporate governance.

6. SUMMARY

Based on the work throughout the year, Internal Audit have concluded that:

- There were adequate and effective internal controls in place throughout the year;
- The Accountable Officer has implemented a governance framework in line with required guidance sufficient to discharge the responsibilities of this role;

In addition, we have not advised of any concerns around the following:

- The format and content of the Governance Statement in relation to the relevant guidance
- The process adopted in reviewing the effectiveness of the system of internal control and how these are reflected
- Consistency of the Governance Statement with the information that we are aware of from our work
- The disclosure of relevant issues

The 2018/19 Internal Audit plan has been delivered in line with the Public Sector Internal Audit Standards.

To conclude, we are satisfied with the consistency of the evidence which supports the Governance Statement with the information available from the work undertaken within Internal Audit.

Agenda Item 2

DUMFRIES and GALLOWAY NHS BOARD

AUDIT AND RISK COMMITTEE

17th June 2019

Final Governance Statement - 2018/19

Author:
Susan Thompson
Deputy Director of Finance

Sponsoring Director:
Jeff Ace
Chief Executive

Date: 28th May 2019

RECOMMENDATION

The Audit and Risk Committee is asked to **discuss and note** the Governance Statement prepared by the Accountable Officer.

CONTEXT

Strategy/Policy:

NHS Dumfries and Galloway are required to produce a Governance Statement, as part of the annual reporting process. This statement needs to be prepared by the Chief Executive, as Accountable Officer, and endorsed by the Audit and Risk Committee.

Organisational Context/Why is this paper important/Key messages:

The Governance Statement is an integral part of the annual reporting and accounting processes as it looks at how the Board has operated within the financial year, giving the appropriate levels of assurance to the Board to allow the Annual Report and Accounts to be signed off.

GLOSSARY OF TERMS

NHS - National Health Service

MONITORING FORM

Policy / Strategy Implications	As part of Governance return.
Staffing Implications	As part of Governance return.
Financial Implications	As part of Governance return.
Consultation / Consideration	Guidance from Scottish Government and further guidance and best practice ideas from both the Internal and External Auditors.
Risk Assessment	As part of Governance return.
Risk Appetite	Low [x] Medium [ ] High [ ]
Sustainability	Not applicable.
Compliance with Corporate Objectives	As part of Governance return.
Local Outcome Improvement Plan (LOIP)	• Outcome 3: Health and wellbeing inequalities are reduced • Outcome 6: People are safe and feel safe • Outcome 8: Individuals and communities are empowered
Best Value	As part of Governance return.
Impact Assessment To ensure NHS Dumfries and Galloway is compliant with the requirements of the annual Governance Statement return process.	

1. The Audit and Risk Committee is asked to note the contents of the Governance Statement prepared by the Accountable Officer and presented as part of the 2018/19 Annual Report and Accounts. This is attached at **Appendix 1**.

2. As in previous years a quick guide has been prepared and is attached at **Appendix 2** to provide the back up to the Governance Statement.

C) The 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 the organisation.

In accordance with IFRS 10 (Consolidated Financial Statements) the Annual Accounts consolidate the Dumfries and Galloway Health Board Endowment Funds and in accordance with IAS 28 consolidate the Integrated Joint Board. This statement includes any relevant disclosure in respect of these.

Purpose of Internal Control

The system of internal control is based on an ongoing process designed to identify, prioritise and manage the principal risks facing NHS Dumfries and Galloway. 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 NHS Dumfries and Galloway accords with guidance from Scottish Ministers in the Scottish Public Finance Manual (SPFM) and supplementary NHS guidance, and has been in place for the year 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.

Governance Framework

NHS Dumfries and Galloway Board operate as a board of governance in line with Scottish Government legislation with its key focus to provide strategic leadership and direction for the local NHS system as a whole.

The overall purpose of the Board is to provide strategic leadership and direction, and ensure the efficient, effective and accountable governance of the local NHS system.

Specific roles of the Board include:

- improving and protecting the health of the local people;
- providing an improved health service for local people;
- focusing clearly on health outcomes and people's experience of their local NHS system;
- promoting integrated health and community planning by working closely with other local organisations; and
- providing a single focus of accountability for the performance of the local NHS system.

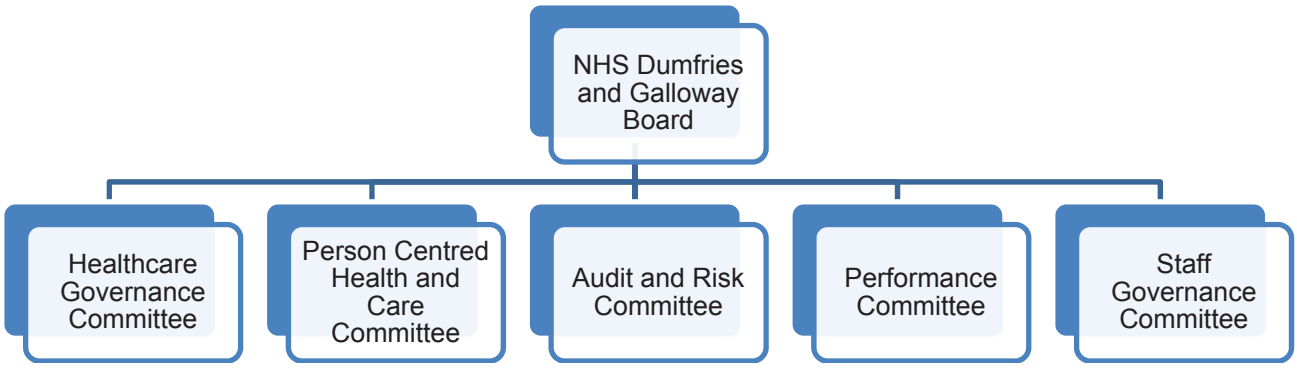
The work of the NHS Board includes:

- strategy development - to develop a single Local Health Plan for the area;
- implementation of the Local Health Plan and Annual Operational Plan;
- resource allocation to address local priorities; and
- performance management of the local NHS system.
- knowledge relating to both risk assessment and risk management.

With the introduction of the Health and Social Care Partnership in 2016 the Board has been working to integrate health services with adult social care services through the IJB structure. Details of the IJB delegated roles and responsibilities can be found within the IJB strategic plan on the dg change website(www.dg-change.org.uk).

The conduct and proceedings of the Board are set out in its Standing Orders which describe how the Board works and which matters the Board has reserved for its approval, it also includes the terms of reference for each of the standing governance committees. You can find the Standing Orders (and other key documents) on the Board's website under the About Us section (www.nhsdg.scot.nhs.uk).

The table below set outs the standing governance committees for 2018-19:



NHS Dumfries and Galloway strive to consult with all of its key stakeholders, this is a key focus for the year ahead, with further planned on community engagement and co-production. For 2018-19 we continued to communicate with stakeholders in a variety of ways. We routinely communicate with, and involve, the people and communities we serve, to inform them about our future plans of hospitals and services. A formal review where we are held to account in public in respect of our performance against targets is held annually.

The Board has 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 website.

We also strive to engage with staff through various channels to allow greater engagement with staff, and encourage more staff to be involved in contributing to decision making in the areas in which they work. We have well established methods of communication through the intranet, a range of newsletters and director and manager briefings.

The Board has a Whistleblowing policy in place for staff which includes the disclosure internally or externally by staff who have concerns about patient safety, malpractice, misconduct, wrongdoing or serious risk and fully supports the national Whistleblowing Policy. Two senior managers are appointed as Whistleblowing confidential contacts, who are available to staff to raise appropriate concerns in a confidential manner. The Workforce Director is the Boards designated whistleblowing lead and the Board has nominated a Non-Executive member as Whistleblowing champion. During 2018-19 the organisation received one anonymous Whistleblowing case. This was fully investigated and corrective action was taken promptly to address the issues raised.

Board members are appointed by Scottish Ministers and are selected on the basis of their position or the particular expertise which enables them to contribute to the decision making process at a strategic level. The Non-Executive members of the Standing Committees have the opportunity to scrutinise and challenge the Board's executive management. The table below demonstrates the activity of the NHS Board and Standing Committees in 2018-19:

COMMITTEE	CHAIR	MEETINGS HELD
NHS Dumfries and Galloway Board	Mr P Jones / Mrs P Halliday / Mr N Morris	7
Healthcare Governance Committee	Mrs P Halliday	4
Person Centred Health and Care Committee	Mrs P Halliday	6
Audit and Risk Committee	Dr L Douglas	4
Performance Committee	Mr P Jones / Mrs P Halliday / Mr N Morris	4
Staff Governance Committee	Ms G Stanyard/ Ms L Bryce	6

In addition to the above structure the Information Assurance Committee is responsible for ensuring the appropriate governance arrangements are in place for information sharing and security within the Board. This committee reports directly to the Audit and Risk Committee on its activity throughout the year. The remit of this group is currently under review to ensure that the appropriate level of representation on the group and the relevant assurances are being provided to Audit and Risk Committee.

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 Scottish Government Health and Social Care Directorates guidance, determined by the Remuneration Sub-Committee who ensure the application and implementation of fair and equitable systems for pay and for performance management on behalf of the Board.

To ensure that the Board complies with relevant legislation, regulations, guidance and policies, a process is in place for identifying, reviewing, disseminating and implementing publications. A central register of circulars is maintained by the Board Corporate Business Manager listing reference, date issued, topic, distribution, date distributed within NHS Dumfries and Galloway and action confirmed by the lead director. Circulars are distributed as issued to the responsible Director and others as appropriate. The Director is responsible for ensuring that required actions are taken and that circulars are disseminated. There is an obligation for Directors to respond to the Board Corporate Business Manager detailing action taken.

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 NHS Dumfries and Galloway complies with relevant legislation, governance, audit and controls assurance requirements.

All policies, strategies or procedures are planned for review every 3 years as a minimum, or sooner if there is a specific legislative or service requirement or change in guidance, law or practice.

Non-Executive Directors have a supported orientation and induction to the organisation as well as a series of in depth development workshops identified during the year. Opportunities for development also exist, at a national level, for some specific non executive roles such as Chairman, Area Clinical Forum Chairs and Employee Directors.

All Board Executive Directors and senior managers undertake a review of their development needs as part of the annual performance management and development process. Access to external and national programmes in line with their development plans and career objectives is supported. The Chief Executive is accountable to the Board through the Chair of the Board. The Chairman agrees the Chief Executive's annual objectives in line with the Board's strategic and corporate plans.

The principles of best value are incorporated within the Board's planning, performance and delivery activities to foster a culture of continuous improvement. Best value is part of everyday business and integral to the Board's decision making in all key areas. The Board's governance committees are integral to the delivery of best value principles and their respective remits have been revised to evidence this responsibility. Directors and managers are encouraged to review, identify and improve the efficient and effective use of resources. I can confirm that arrangements have been made to secure Best Value as set out in the Scottish Public Finance Manual (SPFM).

Assessment of corporate governance performance

During the year, the Board assessed its own performance using the NHS Scotland Board Diagnostic (self-assessment) Diagnostic Toolkit to demonstrate compliance with the UK Corporate Governance Code. The

questionnaire was completed by all Board members and taken forward for discussion at a workshop with the findings being presented to April 2019 Audit and Risk Committee. The intention for 2019-20 is to review the action plan that has been drafted which will focus on improving individual and collective skills and competencies through training; increasing knowledge and understanding of the business and that of the Board's multi agency partners and the wider community through workshops, visits, conferences and engagement; and develop, demonstrate and deliver leadership through challenge days.

In addition particular reference can be made to the following actions taken during the year to reflect on the effectiveness of systems of governance:

- The terms of reference for Committees including the core function and membership have all been reviewed during the year.
- Audit and Risk Committee carried out a self assessment and used the results to identify further areas of improvement for the year ahead. The output from this Self Assessment exercise was discussed at Audit and Risk Committee and reviewed by the Board Chair and the Audit and Risk Committee Chair to identify development needs for Non-Executive Board Members and any required changes to improve Audit Committee effectiveness and work is progressing on a development programme for members.
- The Board held a formal Annual Review where it was held to account in public in respect of performance against targets. The Board held a Public Annual Review for 17/18 following the IJB Annual Review in September 2018. A Ministerial Review for 17/18 was held on 1st April 2019 which was open to the public.
- A number of workshops were facilitated during the year for Board members including an understanding of the annual accounts; community engagement/community empowerment and participation; Board diagnostic, governance review; quality management systems; organisational culture and engaging with the professional advisory committees and Area Clinical Forum.
- We continued the process of embedding our CORE values (Compassionate, Open, Respectful and Excellent) through corporate induction training, awareness sessions and targeted communication.
- Risk is a standing agenda item on Audit and Risk Committee and continues to be a key focus of the committee receiving assurances on the corporate risk register and local project specific risk registers.
- The Strategic Capital Programme Board continues to operate overseeing the delivery of the strategic capital plan as well as acting as a Programme Board for significant projects being taken forward including the Mountainhall Building Project.
- Leadership walk rounds continue to operate monthly and have an open invitation to non-executive members to attend.
- Performance against Operational Plan trajectories is subject to external scrutiny through Mid Year and Annual Accountability Reviews with SGHSCD. Internally, progress is reviewed periodically with each of my Directors and, at least annually, directorate teams present to other Board Directors to ensure effective scrutiny of performance against all aspects of professional standards;
- An assessment of the Boards position in relation to demonstrating best value has been carried out and an action plan will be developed to progress the areas where improvement could be made.
- A short life working group was established to review the arrangements for the Information Assurance Committee during 2018/19, chaired by a Non Executive Member. The outcomes and improvements of the review will be embedded in the operation practice of the committee moving forward.
- The Chief Officer of the IJB has undertaken a review of the governance arrangements for the IJB and its relationships and interactions with the NHS Board and Local Authority.
- In February SG published its blue print for governance. The Board are currently developing an improvement plan to look to implement the recommendations and good practice in Dumfries and Galloway following a self assessment and workshop process led by the Director of Finance and Corporate Business Manager.

Review of Adequacy and Effectiveness

As Accountable Officer, I am responsible for reviewing the adequacy and effectiveness of the system of internal control. My review during the year has been informed by:

- regular review meetings with the executive and senior managers who are responsible for developing, implementing and maintaining internal controls across their areas. Each has provided me with certificates of assurance for the purposes of informing this Governance Statement;
- a review of key performance and risk indicators;
- the minutes and papers presented to the Board which demonstrate that the Board met regularly during 2018/19 to consider its plans and strategic direction, to allocate resources, to review the management of performance and to receive minutes and reports from its Standing Committees;
- Confirmation through the annual statements of the standing governance committees that they have worked effectively in 2018/19. All statements have been prepared by the lead Executive Director and Non Executive Chairperson and submitted to the committees for approval;
- the work of the internal auditors, who submit to the Audit and Risk Committee regular reports which include their independent and objective opinion on the effectiveness of risk management, control and governance processes, together with recommendations for improvement. Internal Audit deliver their work based on an approved risk based plan and are compliant with Public Sector Internal Audit Standards. Regular reports are provided to Audit and Risk Committee which monitor the progress of remedial action plans against previous Limited Assurance audits of which there are currently two from previous years with outstanding actions. No audits completed during the current year have been assessed as providing Limited Assurance.
- comments made by the external auditors in their management letters and other reports;
- A range of topics covered by the Board workshops which develop the knowledge and awareness of both Executive and Non Executive Directors;
- A review of any external inspection report received by the Board.

Risk Assessment

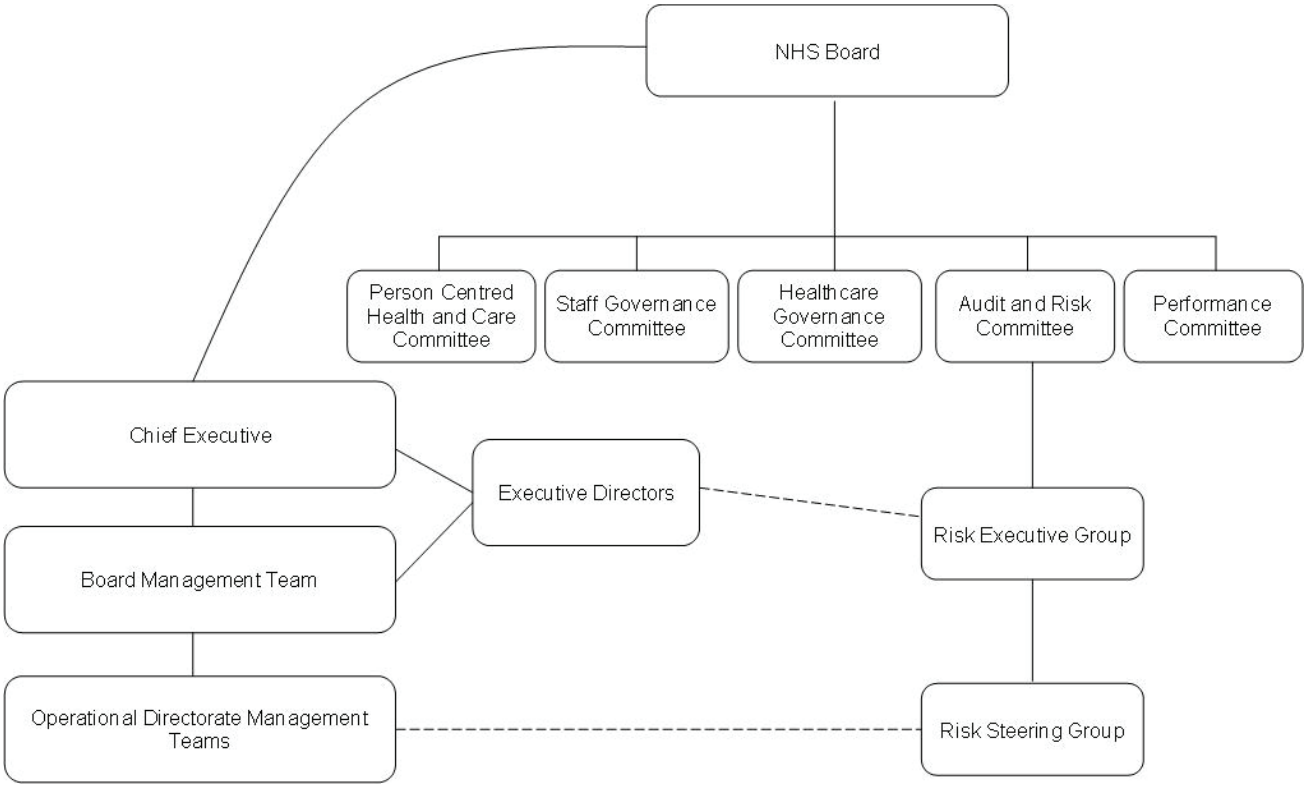
NHS Dumfries and Galloway are subject to the requirements of the SPFM and must operate a risk management strategy in accordance with relevant guidance issued by Scottish Ministers. The general principles for a successful risk management strategy are set out in the SPFM.

NHS Dumfries and Galloway have a risk management strategy in place which forms a key part of the systems of internal control.

The aims of the strategy are:

- To minimise risk and, in particular, the risk of harm to patients
- To create a culture of continuous improvement
- To enable a positive approach to risk management
- To develop and promote policies and procedures that support practitioners and managers in risk decisions
- To provide an educational framework that encourages the sharing of knowledge relating to both risk assessment and risk management.

The following table shows the reporting structure for the management of risk within the Board:



The Risk Executive Group continues to provide the direction of the Risk Management strategy and risk agenda for NHS Dumfries and Galloway. This group report through to the Audit and Risk Committee on a quarterly basis to provide assurance on the effectiveness of the arrangements in place. The Board considers an annual report on risk management. The 2018/19 report will be reviewed by Audit and Risk Committee in June 2019 and then taken to Board following that.

Corporate Risks continue to be managed by the Risk Executive Group and reported to Audit and Risk Committee and below that a formal system of risk identification and evaluation is embedded throughout the organisation and reported through to the Risk Steering Group.

The table below shows the 17 corporate risks that the Board is currently managing along with the current and target risk levels along with the shift from last year. During 2018/19 one additional corporate risks have been added (number 17) in relation to Brexit, two have increase in risk level and two have been reduced.

	Risk Title	Risk Description	Current Risk Level	Last Year Risk Level	Target Risk Level
1.	Sustainable Workforce	Failure to recruit and retain essential and sustainable workforce poses a significant risk to service sustainability.	Very High	Very High	Medium
2.	Finance	Failure of the Board to meet financial target	High	High	High
3.	Infrastructure	Infrastructure is inadequate to meet both physical and technological service user needs in future.	Medium	Medium	Medium

	Risk Title	Risk Description	Current Risk Level	Last Year Risk Level	Target Risk Level
4.	Health Inequalities	Failure to address inequalities resulting in poorer health outcomes for certain groups or parts of the population.	High	High	High
5.	Vulnerable Individuals	A person dies or comes to significant harm as a result of failure to protect vulnerable individuals / support families.	High	High	Medium
6.	Redesign	Unable to redesign quickly enough to meet the demands of the service. Services will need to be redesigned to address demographic / workforce / financial realities into 2020s.	High	High	Medium
7.	Health and Wellbeing of staff	Failure to realise optimal health and wellbeing of staff impacts adversely on service delivery and financial sustainability.	High	High	Medium
8.	Quality of care	Failure to assure and improve quality of care and services.	Medium	Medium	Medium
9.	Change Capacity	Loss of focus on operational delivery due to other significant change programmes, such as the Integration of Health and Social Care and the Primary Care Transformation Programme.	Medium	High	Medium
10.	Health and Wellbeing of our Population	Failure to take action on prevention and early intervention which impacts on future health and wellbeing of our population in medium to long term.	High	High	Medium
11.	Emergency Planning	Emergency Planning – failure to plan for major incidents and disasters. This could lead to harm to patients & staff (as well as reputational damage) through the failure of effective business continuity processes.	Medium	Medium	Medium
12.	Information Security	Failure to maintain information security standards leading to loss of reputation and severe financial penalty.	High	Medium	Medium
13.	Corporate Governance	Board breaches compliance with standards on Corporate Governance including risk of best value not being obtained.	Medium	Medium	Medium
14.	Strategic Planning	Strategic commissioning fails to identify and adequately plan for the health and care needs of the people of Dumfries and Galloway	Medium	High	Medium
15.	Information sharing with and across Children's Services	Potential confusion exists around information sharing due to changes in legislation regarding information sharing across professional groups within Children's Services. This can allow practitioners and children potentially to be at risk due action or omission.	High	High	Medium

	Risk Title	Risk Description	Current Risk Level	Last Year Risk Level	Target Risk Level
16.	Organisational culture and development (staff experience)	Failure of the organisation to have a culture, systems and processes in which staff feel safe and confident to speak up and raise concerns and ideas for improvement, resulting in adverse impact on staff and/or patient safety, health, wellbeing and/or relationships and reputation of the Board.	High	High	Medium
17	Impact of Brexit	Exit from EU creates disruption to required availability of staff, goods and services necessary for the provision of safe care.	High	New risk for 18/19	High

The addition of a new corporate risk – Impact of Brexit (17) relates to the impact Brexit will have on the operational capacity of the Board, specifically around the disruption to staffing, goods and services necessary for the provision of safe care to our population. This risk is of significant concern to the Board and has been given a High risk grading as if no deal for exiting the EU is agreed then there will be immediate disruption to our services through the lack of equipment, medication, provisions and staffing due to the changes to legislation. Likewise if a deal is agreed that fails, this will not have as immediate an impact as a no deal arrangement, but will still impact on the delivery of services that we are able to provide safely to our population. To help to mitigate this risk the Board has already developed Business Continuity Plans to help maintain a safe level of service delivery for a short period of time and new strategies are being prepared for non-EU recruitment and retention of staff. National Procurement and Scottish Government are developing plans to ensure contingencies are in place around the continuous delivery of equipment and medicines for up to 12 weeks after the country exits from the EU at the end of March 2019.

Corporate Risk 12 for Information Security has been escalated during the year. During the year a request from Audit and Risk Committee to review the working arrangements of the Information Assurance Committee was sought. Although the new Information Assurance Committee has been implemented with a revised terms of reference and the first meeting has taken place, it still requires to demonstrate that the appropriate level of assurance is being provided before reducing the risk scoring.

The Sustainable Workforce risk continues to be held at Very High during the reporting period, escalated in the prior year. This risk continues to reflect the complex local, regional and national workforce supply and demand equation across our workforce, especially of clinical staff. The Board, Performance Committee and Staff Governance Committee continue to receive regular updates on medical and wider workforce recruitment and retention work being undertaken throughout the year and the Board have participated in available and relevant national and regional initiatives, as well as undertaking a wide range of local recruitment and retention initiatives, in order to minimise and mitigate the service and financial impact of supply shortages in key disciplines across our workforce. The Board have tried a wide range of approaches to seek to recruit new clinicians, with some success, however the national and international workforce supply challenges, coupled with the aging demographic of our workforce, has resulted on the very limited net positive impact overall. We have now committed to additional investment in 2019/20 in order to build our recruitment team capacity and capability.

All directorates within the organisation maintain risk registers which are scrutinised at the relevant management team as well as being monitored in departmental performance reviews. Risks that threaten the achievement of corporate objectives as well as of any escalated/uncontrolled risks from the directorates are considered by the Risk Executive Group and Management Team. In addition relevant sections of the risk register are reviewed periodically by each of standing committee, the corporate risk register is a standing item of the Audit and Risk Committee agenda. Business cases, board papers, and project plans are also required to have a risk assessment to ensure relevant issues are identified and appropriately managed. Risk registers are held individually for each key development being progressed and are presented routinely to Audit and Risk Committee for scrutiny.

In respect of clinical governance risk we continue to have a strong commitment to clinical effectiveness and quality improvement across the organisation. This is managed through a sound cycle of annual clinical governance reporting arrangements for operational directorates and performance management framework that provides the context to support statistics with a high level of qualitative information.

There are training programmes available to all staff which includes training on risk assessment, hazardous substances, general awareness of safety and display screen equipment risks. Practical training sessions provided by the organisation include a range of moving and handling training for staff primarily involved in patient handling, and also training for staff who may be exposed to violence and aggression.

NHS Dumfries and Galloway recognise that risk management in the NHS is changing and required to adapt. The ongoing review and development of risk management arrangements in year has improved our overall assurance arrangements for risk.

Disclosures

During the previous financial year, no significant control weaknesses or issues have arisen, and no significant failures have arisen in the expected standards for good governance, risk management and control.

Appendix 2

DUMFRIES AND GALLOWAY NHS BOARD

Governance Statement
Quick Guide

For Year Ended 31 March 2019

Overview

All Boards are required to include a Governance Statement within its published Annual Report and Accounts for which the Accountable Officer (Chief Executive) takes personal responsibility for.

The Governance Statement should cover the accounting period and the period up to the date of signature and provide the reader with a clear understanding of the organisation's internal control structure and its management of resources. The statement should be informed by work undertaken throughout the period to gain assurance about performance and risk management, providing an insight into the organisation's risk profile and its responses to identified and emerging risks.

The Governance Statement can be found on Page 16 of the Annual Accounts.

Guidance is issued as part of the Manual and a copy is included in the checklist.

Role of Audit and Risk Committee

As highlighted above the Governance Statement is the responsibility of the Accountable Officer and as such Audit and Risk Committee have a scrutiny/challenge role only.

The March 2017 publication "On Board" which is a guide for members of statutory boards indicates that the Audit Committee should:

- **Support** the Board and Accountable Officer by reviewing the scope, reliability and integrity of the assurances provided to them.

The additional guidance included as part of the annual accounts manual states:

- On behalf of the Board, the Audit Committee has a specific responsibility for **reviewing the disclosures** included in the Governance Statement as part of the process for approving the financial statements.

In addition Annex F of the Audit Committee Handbook sets out key lines of enquiry for an Audit Committee in relation to assurances which members may find useful. This list of questions is not intended to be exhaustive or restrictive nor should it be treated as a tick list substituting for detailed consideration of the issues it raises. Rather it is intended to act as a 'prompt' to help the committee ensure that their work is comprehensive.

On assurances relating to the corporate governance requirements for the organisation, how do we know:

- corporate governance arrangements operate effectively and are clear to the whole organisation?
- the Accountable Officer's Governance Statement is meaningful, and that robust evidence underpins it?
- the Governance Statement appropriately discloses action to deal with material problems?

- the Board/Executive is appropriately considering the results of the effectiveness review underpinning the annual Governance Statement?
- the range of assurances available is sufficient to facilitate the drafting of a meaningful annual Governance Statement?
- those producing the assurances understand fully the scope of the assurance they are being asked to provide, and the purpose to which it will be put?
- effective mechanisms are in place to ensure that assurances are reliable and adequately evidenced?
- assurances are 'positively' stated (i.e. – premised on sufficient relevant evidence to support them)?
- the assurances draw appropriate attention to material weaknesses or losses which should be addressed?
- the annual Governance Statement realistically reflects the assurances on which it is premised?

Role of Board Members

In relation to the Boards annual accounts "On Board" describes the following in relation to the role of the Board:

- The Board must ensure that the public body has processes and systems in place to ensure compliance with the Scottish Public Finance Manual (SPFM). Board members should look to the Chief Executive (Accountable Officer) and staff of the public body for advice and assurance that the SPFM is being complied with.
- The Board of a sponsored body is **responsible** for approving the body's annual accounts and ensuring that the Minister is provided with the annual report and accounts to be laid before the Scottish Parliament.

Board Members in order to satisfy their role will place a high level of reliance of the review work undertaken by the Audit and Risk Committee throughout the year and ultimately for the production of the Governance Statement.

Process

The Governance Statement is produced based on the work of the Boards governance arrangements during the year and should cover up to the date of signing, the majority of the formal assurances are therefore collected at year end.

A folder is retained locally within finance which includes all documents which are collated to provide back up to the Statement. The folder will be available in the Non Executives office from 4th – 14th June 2019 for review.

Folder Contents

The table below sets out the structure and contents of the master governance folder which is the back up to the production of the Governance Statement.

If you would like a paper copy of any of the documents noted we are happy to provide these.

Folder Section	Document Types	Detail
Statement	Draft Governance Statement	1. A copy of the draft statement which has been passed to the Auditors and will form part of the Annual Report and Accounts 2018-19.
Guidance	Core Guidance Issued	2. Letter from SG issuing the Accounting Manuals 2018-19. 3. Guidance extract from Manual 4. Pro-forma from manual Annex A.
	All available guidance highlighted within the Core Guidance *(no paper copies provided, if you want a copy please ask)*	5. Extract from the Scottish Government Finance Manual on Governance Statements http://www.gov.scot/Topics/Government/Finance/spfm/govstate 6. Audit Scotland publication 'improving the quality of NHS annual report and accounts: Governance Statements' provides further advice on the presentation of the Governance Statement. http://www.audit-scotland.gov.uk/uploads/docs/um/gp_improving_quality_nhs_accounts_governance.pdf 7. On Board: A guide for Members of Statutory Boards http://www.gov.scot/Publications/2017/03/9182 8. The Good Governance Standard for Public Services Good Governance Standard for Public Services. 9. Memorandum to Accountable Officers from the Permanent Secretary to the Scottish Government http://www.gov.scot/Topics/Government/Finance/spfm/Accountability/aomemo

Guidance cont'd	All available guidance highlighted within the Core Guidance	10. Standards for Clinical Governance and Risk Management http://www.healthcareimprovementscotland.org/previous_resources/standards/clinical_governance_and_risk_m.aspx 11. Scottish Government Audit Committee Handbook http://www.gov.scot/Resource/0053/00533811.pdf 12. Internal Framework: Good Governance in the Public Sector http://www.cipfa.org/policy-and-guidance/standards/international-framework-good-governance-in-the-public-sector 13. Staff Governance Standard https://www.staffgovernance.scot.nhs.uk/media/1342/staff-governance-standard-edition-4.pdf
	Governance Statements from two other Boards.	14. Review of other Boards - NHS Borders - NHS Greater Glasgow and Clyde
Process	Audit and Risk Committee Papers	15. January 2019 Agenda Item 20: Financial Reporting Quarterly Update (Section on Annual Accounts preparation). 16. Grant Thornton Draft External audit Plan
Self Assessment	Self Assessments carried out during the year	17. Audit and Risk Committee Self Assessment 18. Board Diagnostic Self Assessment 19. Best Value Self Assessment

Internal Assurances	Copies of all Director Assurance Letters received	20. Assurance Letters - Director of Finance - Medical Director - Director of Nursing, Midwifery and AHPs - Chief Operating Officer - Director of Workforce - Director of Public Health
	Copies of all Committee Assurance Statements	21. Assurance Statements - Audit and Risk Committee - Healthcare Governance Committee - Performance Committee - Person Centred Health & Care Committee - Staff Governance Committee
Annual Reports	Copies of Annual Reports received	22. Annual Risk Report 23. Annual Information Assurance Report *(Draft, final version will be in A&R papers*)
Independent Assurances	Internal Audit Report	24. Annual Internal Audit Report *(Will be in A&R papers)*
	External Audit Reports	25. Reports from External Audit - Draft Audit Opinion *(The version currently included in draft accounts, relevant comments highlighted, final version in A&R papers)* - ISA 260 Report *(Available as part of A&R papers)*
Disclosures	Additional documents the Accountable Officer reviews to make an informed judgement on whether to make any further disclosures.	26. Performance against non financial targets 27. Unannounced inspection reports - Safety and Cleanliness of Hospitals (DGRI) - Safety and Cleanliness of Hospitals (GCH) 28. File note from Chief Executive

Recommendation

Audit and Risk Committee Members and Board Members are asked to use this quick guide to review the draft Governance Statement provided.

Produced by: Susan Thompson
Deputy Director of Finance
NHS Dumfries and Galloway

31st May 2019

Queries to:
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OUTTURN AGAINST THE 2018-19 INTERNAL AUDIT PLAN AND CONTROLS ASSURANCE STATEMENT

1. Purpose of Report

The internal audit team operates to a plan agreed at the beginning of each financial year. The 2018-19 plan was approved by the Audit, Risk and Scrutiny Committee at its meeting on 10 April 2018. This report provides information about the progress made by internal audit against the plan at the year-end and the conclusions arising from the work done.

2. Recommendations

Members are asked to:

2.1 note and comment on the progress made on the 2018-19 internal audit plan as detailed in **Appendix 1**; and

2.2 note internal audit's Controls Assurance Statement for 2018-19 (**Appendix 2**) which gives a positive assurance on the Council's internal control arrangements for the year.

3. Considerations

Issues in Completing the Internal Audit Plan

3.1 The 2018-19 annual internal audit plan was based on a direct time budget of 564 days. This was allocated across four programme areas of: main financial systems, departmental financial systems, risk management, and grants work. There was also a small contingency for unplanned work.

3.2 The priority for internal audit is main financial systems work. We planned six such audits including one brought forward from the previous year (as a consequence of a secondment to support the DGOne Inquiry). All this work was completed and has been reported to the Committee, along with our follow-up of main financial systems work from 2017-18.

3.3 We also had two audits from 2017-18 which were still in progress at 1 April 2018 (as advised in last year's outturn report); these were concluded and reported to this Committee.

3.4 We planned three departmental systems audits for 2018-19. Two were fully completed and reported by year-end, and the third has now been progressed to draft report stage. This will come to the Committee at its next meeting (September 2019).

3.5 There were three specific risk audits in the plan and this work has been completed and reported. We also completed the LEADER programme audit and issued the annual report (which is submitted to the Scottish Government). As at the date of this Committee meeting therefore, all of the work in the 2018-19 internal audit plan has been done. This is a good position.

3.6 The actual time spent on each programme area during the year is listed in **Appendix 1** along with the planned time and variance. There was a pressure on the plan from the continued secondment at the beginning of the year but in the event, we were able to accommodate this without impact on the plan.

3.7 Overall the team delivered 568 direct audit days for the year against a plan figure of 564 (100% efficiency of adherence to plan days). This is the first of two statistical performance measures reported by internal audit. Later in the calendar year, a further performance indicator relating to the relative cost of internal audit will be compiled. This will be reported when the accounting figures are available.

Controls Assurance Statement for 2018-19

3.8 The work of internal audit is concerned with the following business objectives:

- Effective and efficient operations
- Reliable reporting arrangements
- Compliance with laws and policies

3.9 Internal audit provides an annual controls assurance statement which is a formal document stating whether or not the control framework established and operated by management provides reasonable assurance these business objectives are being met. This is one of the key assurances supporting the Governance Statement, which will be published with the Council's accounts.

3.10 No significant matters arose through internal audit's testing programme and consideration of control issues. An appropriate level of control is considered to have been in place and the overall conclusion is a positive assurance for 2018-19. A formal statement to this effect is provided in **Appendix 2**.

4. Future Developments

4.1 Internal audit is required to operate to the professional standards and practices set out in the Public Sector Internal Audit Standards (PSIAS). The background to PSIAS was given to the Committee as part of the 2019-20 Annual Plan report at the last Committee meeting (February 2019).

4.2 The internal audit team has completed a self-assessment against the current edition of PSIAS. The result of the self-assessment is that internal audit continues to be substantially compliant, with no significant departures from the Standards identified. The next stage is for an external quality assessment (EQA) to be made of internal audit (taking place at least once every five years). The Director of Economy and Resources is making arrangements to procure the EQA which will be undertaken by an independent and experienced external party. The exercise will lead to an improvement plan being developed for internal audit and this will be reported to the Committee later in the calendar year.

5. Governance Assurance

5.1 The remit of the Audit, Risk and Scrutiny Committee has been set by the Council. In adopting the recommendations to note and comment on the progress made and to note the controls assurance statement, the Council will be acting within its legal powers.

5.2 The Corporate Management Team has been consulted on the report and is in agreement with it.

6. Impact Assessment

As this report does not propose a change in policy/strategy/plan/project, it is not necessary to complete an impact assessment.

Author(s)

NAME	DESIGNATION	CONTACT DETAILS
Kevin Geraghty	Internal Audit Manager	01387260179

Approved by

NAME	DESIGNATION
Rhona Lewis	Head of Democratic Services

Appendices - 2

Appendix 1 - Internal Audit Plan 2018-19 – Performance at Twelve Months
Appendix 2 – Controls Assurance Statement 2018-19

Background Papers
Previous reports to Audit and Risk Management Committee at
http://egenda.dumgal.gov.uk/aksdumgal/users/public/admin/kab71.pl?cmte=AUR

APPENDIX 1

INTERNAL AUDIT PLAN 2018-19				
PROGRESS AT YEAR-END				
	Planned	**Actual**		
	Days	**Days**	**Balance**	**Notes**
Task				
1. Non-Audit Time				
Public Holidays	28.0	24.0		
Annual Leave	128.0	128.0		
Other Absence	0.0	3.5		Carer's leave, Mountain rescue
Sick & Medical Absence	20.0	15.0		
Secondment	0.0	26.5		DGOne Inquiry
Total Non-Audit Time	176.0	197.0	-21.0	
2. Indirect Time				
Management, admin and general support	280.0	257.0		
Training	20.0	18.0		
Total Indirect Time	300.0	275.0	25.0	
3. Direct Time				
Main Financial Systems:	280.0	282.5	-2.5	
Council Tax				Reported
Sundry Debtors				Reported
Banking Arrangements				Reported
Treasury Management				Reported
Revenue Budgetting				Reported
Accounting				Reported
2017-18 MFS Follow-ups				Reported
Departmental Financial Systems:	115.0	105.5	9.5	
Employee Travel Expenses				Reported
School Electricity Charges				Reported
Use of Purchase Cards by Schools				Draft report issued
Risk Management				
Risk Management Support (Corporate and Service)	20.0	46.5	-26.5	Policy update and support
Specific key risks and corporate issues:	115.0	91.5	23.5	
Off-Payroll Workers (IR35)				Reported
Benefits in kind from the use of vehicles				Reported
Business Continuity				Reported
Subtotal Risk Management Work	135.0	138.0	-3.0	
Grants Programme:				
EU Grant Certificate - LEADER	14.0	24.0	-10.0	Reported
Unplanned Audit Work	20.0			
CC Financial Governance Review		8.0		Concluded
Additional payments to teachers		10.0		Concluded
Subtotal Unplanned Audit Work	20.0	18.0	2.0	
Total Direct Time	564.0	568.0	-4.0	
ALL TIME TOTAL	1040.0	1040.0	0.0	

APPENDIX 2

To Members of the Audit, Risk and Scrutiny Committee of Dumfries & Galloway Council and the Council's S95 Officer

This is internal audit's assurance statement on the adequacy and effectiveness of the Council's internal control system for the year ended 31 March 2019.

Respective responsibilities of management and internal auditors in relation to internal control

It is the responsibility of the Council's senior management to establish an appropriate and sound system of internal control and to monitor the continuing effectiveness of that system. It is the responsibility of internal audit to assess the robustness of the internal control system and report the conclusion to the Audit, Risk and Scrutiny Committee annually.

Sound internal controls

The main objectives of the Council's internal control systems are:

- To ensure adherence to management policies and directives, in order to achieve the Council's objectives;
- To safeguard assets;
- To ensure the reliability, relevance and integrity of information, securing as far as possible the completeness and accuracy of records; and
- To ensure compliance with statutory requirements.

Maintenance and development of the system of internal financial control is undertaken by managers within the Council. The system is based on a framework of financial regulations and codes, a scheme of delegation and accountability, management supervision, administrative procedures (including separation of duties) and regular management information. In particular, the system includes:-

- Comprehensive budgeting systems;
- Preparation of regular financial reports which indicate actual expenditure against the forecasts;
- Regular reviews of periodic and annual financial reports indicating financial performance against forecasts;
- Setting targets to measure financial and other performance;
- Clearly defined capital expenditure guidelines; and
- Formal project management disciplines.

Any system of control can only ever provide reasonable and not absolute assurance that control weaknesses or irregularities do not exist or there is no risk of material errors, losses, fraud, or breaches of laws or regulations. The Council must therefore continually seek to improve the effectiveness of its systems of internal control.

The work of internal audit

Internal Audit is an independent, objective assurance and consulting activity designed to add value and improve an organisation's operations. It helps an organisation accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control and governance processes.

The Local Authority (Accounts) Regulations 2014 require the Council to: 'operate a professional and objective internal auditing service in accordance with recognised standards and practices in relation to internal auditing.'

The Council's Internal Audit section operates in accordance with the Audit Charter approved by the Audit, Risk and Scrutiny Committee in February 2019, which is based on the principles and standards outlined in the public sector internal audit standards (PSIAS). Internal Audit operated generally in compliance with these standards and there were no significant departures from them during 2018-19.

The Internal Audit section undertakes an annual programme of work based on a risk assessment process, which is revised on an ongoing basis to reflect evolving risks and changes within the Council. The Audit, Risk and Scrutiny Committee approved the internal audit plan for 2018-19 in April 2018.

Any significant matters arising from internal audit work, including non-compliance with important audit recommendations, are reported to the Head of Finance and Procurement as the Council officer designated under S95 of the Local Government (Scotland) Act 1973. Internal audit reports identifying any system weaknesses, non-compliance with established controls and improvement opportunities are issued to applicable Directors and operational management. They are also made available to elected Members.

It is management's responsibility to ensure that proper consideration is given to internal audit reports and that appropriate action is taken on audit recommendations. Internal Audit is required to identify whether action has been taken on its recommendations and that management has understood and assumed the risk of not taking action. Progress on implementing the agreed actions points in internal audit reports is reported to the Audit, Risk and Scrutiny Committee who can 'call in' any service where progress is a concern. The Council's external auditors also arrange to follow up the actions they have agreed with management.

Fraud Reporting

Internal Audit's role includes supporting management in countering fraud through advice and reporting on control weaknesses found during the course of audit work. Internal Audit also co-ordinates the formal reporting of fraud involving sums above £5,000 to the Council's external auditors for onward reporting to Audit Scotland. Council managers are required to notify Internal Audit of all such cases; no frauds were reported in 2018-19.

Basis of Conclusion

Internal audit's evaluation of the control environment that operated during 2018-19 is informed by a number of sources:

- The work undertaken by internal audit during the year to 31 March 2019 and previous years;
- The assessment of risk completed during the preparation of the audit plan;
- Reports issued by the Council's current external auditors, Grant Thornton;
- Knowledge of the Council's governance, risk management and performance monitoring arrangements;
- Assurances provided to auditors by management during the course of audit work.

The level of staffing resources available to undertake internal audit work in 2018-19 was marginally less than planned due to a temporary secondment, but this did not affect internal audit's ability to reach a conclusion on the adequacy and effectiveness of the internal control, risk management and governance arrangements operating during the year. There were no restrictions on internal audit's ability to access the systems, people and records required to complete its work. There were therefore no other impairments on internal audit during the year.

The internal audit programme for 2018-19 addressed the adequacy and effectiveness of key controls in six of the Council's main financial systems. Follow-up work was undertaken for three other main financial systems, based on the reports issued in the previous year. Internal audit work also addressed certain other business processes in accordance with the audit plan. No specific computer audits were undertaken but the main financial systems work included reviews of security structures, access controls and computer backup/business continuity arrangements.

The Internal Audit section is also responsible for providing support on the development and maintenance of risk management in the Council. The scope of activity during the year included support on Service risk registers, advice on risks involved in projects and co-ordination of risk management strategy updates.

Limitation of Scope

In accordance with professional practice, internal audit work is planned and executed on the basis that conclusions can be reached from a sample of transactions. This leaves a possibility that there may be undetected control issues in unexamined transactions.

The conclusion in respect of the main financial systems which were not subject to audit in 2018-19, is dependent on full information having been disclosed to internal audit by management.

The controls assurance statement has been prepared in April 2019 and there remains a risk that a material control weakness could emerge during the preparation of the accounting statements for 2018-19.

The above risks are however considered small.

Conclusion

It is the Internal Audit Manager's conclusion, based on the above, that reasonable assurance can be placed upon the adequacy and effectiveness of the Council's internal control system in the year to 31 March 2019.

J K Geraghty
24 April 2019

DRAFT Annual Governance Statement 2018/19

1. Scope of Responsibility

1.1 Dumfries & Galloway Council is responsible for ensuring that its business is conducted in accordance with the law and proper standards, and that public money is safeguarded and accounted for properly. The Council also has a statutory duty of Best Value under the Local Government in Scotland Act 2003 to make arrangements to secure continuous improvement in performance, while maintaining an appropriate balance between quality and cost; and in making those arrangements and securing that balance, to have regard to economy, efficiency, effectiveness and equalities and to contribute to the achievement of sustainable development.

1.2 In discharging this overall responsibility, Dumfries and Galloway Council is responsible for putting in place proper arrangements for the governance of the Council's affairs and facilitating the effective exercise of its functions. Good governance is about exercising strategic leadership by developing and clearly communicating the authority's purpose, vision and its intended outcomes for citizens and service users.

1.3 This includes setting the strategic direction, vision, culture and values of the Council; the effective operation of corporate systems, processes and internal controls; engaging with and leading the community, monitoring whether strategic priorities and outcomes have been achieved; ensuring that services are delivered cost-effectively; maintaining appropriate arrangements for the management of risk and ensuring that the Council complies with the requirements on the Role of the Chief Financial Officer in Local Government, contained in the Chartered Institute of Public Finance and Accountancy's (CIPFA's) 2010 Statement, and the Local Authority Accounts (Scotland) Regulations 2014.

2. The Purpose of the Governance Framework

2.1 The governance framework comprises the systems and processes, culture and values which direct and control Dumfries and Galloway Council's activities and through which the Council accounts to, engages with and leads the community. It enables the Council to monitor achievement of the Community Planning Vision and Principles and the Outcomes which are set out in the region's Local Outcomes Improvement Plan, Locality Plan on food sharing and the Council's four Priorities and sixteen Commitments.

2.2 The Council has during 2018/19, been updating its Local Code of Corporate Governance. A copy of the Code will be able to be downloaded at www.dumgal.gov.uk.

3. The Governance Framework

The governance framework has been in place at Dumfries and Galloway Council for the year ended 31 March 2018 and up to the date of approval of the Annual Accounts. The Council's governance arrangements are consistent with the CIPFA/SOLACE good practice guidance and are detailed below.

3.1 Identifying and Communicating the Authority's Vision of its Purpose and Intended Outcomes for Citizens and Service Users

- At the meeting of Dumfries and Galloway Council on Tuesday 26 September 2017, Councillors agreed its four Priorities and sixteen Commitments and a detailed Council Plan for the next five years to ensure these are delivered. The four Council Priorities target the most important areas of Council services; on improving the region economically and also ensuring better lives for our children and other vulnerable groups.

- Our Council's Priorities:
  - Build the local economy;
  - Provide the best start in life for all our children;
  - Protect our most vulnerable people;
  - Be an inclusive council.

- These Priorities and Commitments are used by Elected Members in considering strategic decisions, determining key performance measures, and allocation of resources. The Priorities have featured in consultation and engagement on the Council's budget decisions.

- The Council is a key partner in the region's Community Planning Partnership Board the and in 2017 agreed a Local Outcomes Improvement Plan and Locality Plan on food sharing 2017-2027. This is promoted on the Council's website and features in communications including social media.

3.2 Reviewing the Authority's Vision and its Implications for the Authority's Governance Arrangements

- In June 2017 the Council received a progress report in delivering its Priorities and Commitments for 2016-17, in relation to the previous Council. As noted above, a new Council Plan was developed and agreed. The Best Value Assurance Report recognises the Council's priorities have been maintained over five Administrations and reflected in Council Plan, Strategies and Policies.

- The Council had also agreed in May 2017 the adoption of Standing Orders and a Scheme of Administration and Delegation to Committees as well as a Scheme of Delegation and Responsibilities to Officers and Statutory Appointments and a Committee Size, Proportionality and Appointment to Chairs, Vice Chairs and Senior Councillor Positions.

- As a result of a new management structure agreed in February 2019, the Scheme of Delegation to Officers was further revised in March 2019 and changes to the Scheme of Delegation to Committees will follow in June 2019.

3.3 Translating the Vision into Objectives for the Authority and its Partnerships

- The Council Plan set out in detail how and through which Services the Priorities will be delivered and where this will include and involve partners. These were reflected in four Directorate Business Plans which are now being translated into Service Business Plans.

- The Council's Performance Management Framework provides for high level Business Plans that set out what the Council Plan is planning to achieve; and there are six monthly and annual reports on the achievement of these Plans. The Best Value Assurance Report recognises the Performance Management arrangements have improved since our previous Audit in 2009, although these should be improved further.

- Each Business Plan details how each Directorate is contributing to the Council's Priorities, service objectives, resources (including staff and assets) that will be applied, improvement actions and key performance indicators.

- Performance Reports are presented to Service and Area Committee providing an update on performance for the services through key performance indicators and dates for projects and accompanying narrative to present the wider context. A new approach during 2018/19 has been the involvement of community groups at Area Committees to illustrate projects.

During 2018/19, the Council progressed its business through the Scheme of Delegation to Corporate, Strategic Service and Area Committees (alongside a number of other committees) with key roles provided by the following Committees:

Policy and Resources Committee

- Develops and approves corporate policy and strategies to further the Council's Priorities and the Local Outcomes Improvement Plan in partnership with other public bodies, third sector and private organisations, communities and the public ensures the effective use, including shared services development, of the Council's financial and non- financial resources, including people, property (asset management planning) and technology, to further the Council's Priorities.

Communities Committee

- Oversees the strategic development and management of, and to exercise all functions in relation to, Customer Services, Cultural Services; Civic and Local Services; Revenues and Benefits; Welfare Advice and Financial Inclusion; Registration; Tackling Poverty; oversees the strategic development and management of, and to exercise all functions in relation to, community empowerment including community development, engagement, planning and Ward Working; community safety; and community resilience and emergency planning.

- Exercises the functions of the Council in connection with Community Councils; receives monitoring and performance reports on commissioned services.

- Exercises the functions of the Council as strategic housing authority.

- Considers strategic and policy issues arising from Welfare Reform.

Audit, Risk and Scrutiny Committee

- To ensure that Best Value is achieved in the decision-making process, through the impact of decisions on policy and in service delivery.

- To scrutinise the performance of the Council in relation to its policy objectives, priorities and performance targets on individual service areas.

- To hold the Policy and Resources and other Committees to account for developing and implementing policy.

- To ensure the effectiveness of local reporting and scrutiny arrangements on an annual basis.

- To consider external inspections and value for money reports and their application, including value for money audits on funding of external bodies.

- To make recommendations to the Council arising from the outcome of the Scrutiny process.

- To review the performance of the Policy and Resources and other Committees in fulfilment of their remits and delegations.

- To set key performance indicators and targets in respect of the scrutiny function and to assure continuous improvement, to be monitored by Area Committees.

- To ensure that the scrutiny function is embedded into the remits and work plans of all Committees of the Council.

- Independent assurance of the adequacy of the risk management framework and the associated control environment within the Council to provide reasonable assurance, effective and efficient operations and compliance with laws and regulations.

- To review the activities of the Internal Audit function, including its annual work programme and progress against the programme and the outcome of major findings of Internal Audit investigations.

- To review all matters relating to external audit, including audit plan, action points and reports, and to monitor implementation of external audit recommendations.

- Respond to issues raised in relation to corporate policies, performance information, inspection and audit reports, accident statistics and Health and Safety costs and any other matters deemed necessary.

- Preparation of an annual report on the work and performance of the Audit and Risk Management Committee.

- Role in development of the Council's Code of Corporate Governance and Annual Governance Statement.

- Provision of an independent assurance on the integrity of financial reporting and annual governance processes.

- Receive quarterly updates on the use of the Regulation of Investigatory Powers (Scotland) Act 2000.

- To set key performance indicators and targets to be monitored by Area Committees

The main committees up until May 2019 were:

- Audit, Risk and Scrutiny Committee
- Children, Young People and Life Long Learning Committee
- Communities Committee
- Dumfries and Galloway Council
- Economy, Environment and Infrastructure committee
- Licensing Panel
- Local Review Body
- Planning Applications Committee
- Social Work Services Committee

The Committee structure is being revised as a consequence of management restructuring and will be amended in due course.

The Best Value Assurance Report recognised scrutiny and challenge taking place across all Service Committees.

3.4 Measuring the Quality of Services for Users, Ensuring they are delivered in Accordance with the Authority's Objectives and Ensuring that they represent the Best Use of Resources and Value for Money

- In September 2017, the Council approved a 5-year Council Plan. The Plan incorporates the Administration's Partnership Agreement commitments and reflects the objectives within the main Council strategies, and the existing Council Priorities. The Plan also provides alignment with financial and workforce strategies and incorporates provision for delivery, monitoring and reporting of the Plan's commitments through Directorate Business Plans. This provides the strategic focus and direction, setting out what the Council will deliver over the period of the Plan 2017-2022.

- In line with the introduction of the new Council Plan, the Planning and Performance Framework was refreshed. The Framework enables managers, staff, members of the public, Elected Members and all stakeholders to see how it is performing and make comparisons with its historic performance and that of other councils. This Framework also allows for a consistent approach to the way service performance and quality is managed, monitored, reviewed and reported ensuring the Council is honest in evaluation of its performance, ensuring that it learns from its results and improves what it does.

- This Framework, together with the Business Planning Guidance (originally agreed in 2011, updated by Full Council in December 2014 and refreshed in September 2017 in line with the Council Plan), allows the Council to focus consistently on performance across all Services and acts as a tool to strengthen the culture of the organisation. Both of these are regularly reviewed and updated, based on learning and good practice. The Best Value Audit Improvement Plan includes a Review of our Performance Management arrangements.

- Workforce Planning information is embedded within the Council Plan and also within Directorate Business Plans. This provides for effective future workforce planning running alongside the Council's transformation programme which will run for the life of the Council Plan. As recognised within the Best Value Assurance Report, we are introducing an overarching Workforce Plan linked to our financial savings and transformation programme.

- A key function of the Audit Risk & Scrutiny Committee is to scrutinise the performance of the Council to ensure Services secure value for money and the best use of resources. The Council agreed a Scrutiny Handbook in 2012 which provides information and guidance on the operating principles and techniques of the Committee. This is currently under review and being updated by the Committee. Integral to the Scrutiny & Performance Committee work programme is a series of Reviews which the Committee determined and are conducting, focusing on the effective and efficient arrangements and to identify areas of good practice. The Committee conducted two reviews during 2018/19:
  - Grow The Local Economy Through The Procurement Process; and
  - Improve Our Support and Vulnerable People Through Improved Data Sharing Arrangements.

- A range of benchmarking and qualitative comparison is carried out in individual Services, through professional organisations, national groups and dedicated quality and benchmarking organisations. This activity is encouraged and Services continue to use this information to assess their performance, in terms of cost, quality and customer satisfaction. This information is used to inform action on Service improvement. Year on year performance information and comparator benchmarking data is being embedded in Business Plan performance reports.

- The Accounts Commission requires councils to provide full coverage of the Local Government Benchmarking Framework (LGBF) data within their public performance reporting arrangements; and this information is now available on the Council's website together with supporting information on related improvement activities.

- Dumfries and Galloway Council continues to be involved in the LGBF family group benchmarking process which was introduced to promote dialogue between Councils on where good practice lies and to share it across councils. In doing so, the intention is to better understand factors that each council can control in improving its costs against its performance achievements.

Appropriate staff members from the relevant services continue to participate in these activities.

- The Council's ongoing commitment to continuous improvement can be demonstrated through the continued use of Public Service Improvement Framework (PSIF). Following an organisational wide capability assessment, a programme of assessments was introduced to support Heads of Service to recognise areas of good practice and to identify improvement opportunities. The approach to conducting the PSIF assessment was strengthened through the introduction of cross-directorate assessment teams and providing the opportunity for increased participation from staff within the services to be involved. This changed approach has led to a more robust assessment process, allowed the sharing of experience and knowledge across the assessment team and improved the quality and relevance of the resultant improvement activities. The use of challenge panels to challenge the findings and improvement actions continues.

3.5 Defining and Documenting the Roles and Responsibilities of the Executive, Non-Executive, Scrutiny and Officer Functions, with Clear Delegation Arrangements and Protocols for Effective Communication in respect of the Authority and Partnership Arrangements

- The Council has in place a comprehensive Schemes of Delegation for Officers. This was reviewed as a result of the management restructure and approved in March 2018.

- The Council's Member Officer Protocol (MOP) serves to guide relationships between Members and Officers and lays out the arrangements for Member involvement in a range of activities including local issues. The MOP incorporates a Media Protocol which embraces the Code of Recommended Practice on Local Authority publicity. This was updated in 2018/19.

- Service Committees, Area Committees and the Scrutiny and Performance Committee have a clear remit to scrutinise the performance of the Council in relation to its policy objectives, priorities and performance targets on individual service areas and also to ensure that Best Value is achieved in the decision making process, through the impact of decisions on policy and in service delivery.

- The Council is committed to partnership working and has in place relevant joint strategies and action plans which are agreed by appropriate Committees.

- A particular focus for partnership arrangements has been in health and social care with the Integration Joint Board (IJB) and the Health and Social Care Partnership. The Health and Social Care Integration Scheme was adopted by Full Council in March 2015 and since then the IJB has adopted its Strategic Plan and Locality Plans for 2016-19; its Financial Plan and locality arrangements; its Equality Outcomes. All of this work has assisted in documenting and establishing the different roles and responsibilities of the partners and of the IJB itself.

- The respective roles and responsibilities of the IJB and the Council have been defined and documented. A paper is being developed by the IJB to ensure that these are better explained to officers and elected members.

3.6 Developing, Communicating and Embedding Codes of Conduct, Defining the Standards of Behaviour for Members and Staff

- Dumfries and Galloway Council has adopted the National Code of Conduct for Employees (with amendments) as its Local Code. The Code sets out the minimum standards of conduct expected of Council employees. It incorporates 'The seven Principles of Public Life' identified by the Nolan Committee on Standards in Public Life and adapted for a local government context.

- The Council has adopted the Standards Commission's Code of Conduct for Elected Members. Each Member undertook to meet the requirements of this Code as part of their declaration of acceptance of office. Training was delivered for new Members taking office in May 2017, based on a presentation provided by the Standards Commission.

- The Member Officer Protocol serves to guide Members and Officers of the Council in their relations with one another and reflects the principles underlying the respective Codes of Conduct which apply to Members and Officers.

3.7 Reviewing the Effectiveness of the Authority's Decision-Making Framework, including Delegation Arrangements, Decision Making in Partnerships and Robustness of Data Quality

- The Council has continued to enhance and strengthen its decision-making framework through its Review of Standing Orders Sub-Committee which is remitted to keep the Council's Standing Orders and Schemes of Delegation under review.

- Each committee report is subject to governance checks which cover legal implications, financial, considerations and also the adequacy of information and data provided to enable Elected Members to come to a decision. In addition, each Committee Report is required to evidence the outcome of its Impact Assessment - the approach of the Council is a generic IA covering the statutory requirements of equalities, environmental and climate change and since June 2018, the new Fairer Scotland Duty about inequality; and also takes into account health inequalities, social and economic sustainability.

- An extensive review of the Schemes of Delegation and Administration was undertaken and approved by Full Council in September 2016. These have been kept under review and updated as necessary.

- The Review of Standing Orders Sub Committee meets regularly and works to develop and improve the Council's Standing Orders to meet new needs and challenges and to deliver what is expected in terms of robust decision making, fairness and transparency.

- Our Council's four Area Committee Chairs and four Vice Chairs and the Senior Leadership Team held a programme of quarterly meetings to review the operation of Area Committee meetings and look at future business; and in addition, the Senior Leadership Team met with the Members of each the four Area Committees in their locality to discuss service issues in that locality.

3.8 Reviewing the Effectiveness of the Framework for Identifying and Managing Risks and Demonstrating Clear Accountability

- The Audit Risk and Scrutiny Committee has a remit for the independent assurance of the adequacy of the risk management framework and the associated control environment within the Council to provide reasonable assurance of effective and efficient operations and compliance with laws and regulations.

- New risk management arrangements have been put in place during 2018/19. Each Directorate has its own risk register and the management of risk is now integral to Business Plans, and reported to Service committees.

- The Council has a legal duty under the terms of the Civil Contingencies Act 2004 to have Business Continuity (BC) Management arrangements in place. Each Service across the Council has its own BC Plan, as well as a designated BC Coordinator with responsibility to maintain those arrangements and to ensure those within the service have a suitable level of awareness and understanding.

- At a Corporate level, the Essential Services Continuity Group has a key role in managing widespread Continuity issues which affect a number of Services, and require Strategic direction in terms of prioritisation of resources. A regime of maintenance, testing and exercising is in place to ensure these arrangements are fit for purpose, and continue to be so.

3.9 Ensuring Effective Counter-Fraud and Anti-Corruption Arrangements are Developed and Maintained

- The Council has Financial Regulations and Procurement Standing Orders in place which are subject to regular review to take into account best practice and legislative changes. A substantial review of Procurement Standing Orders has taken place during 2018/19.

- The Council's financial control framework is considered adequate to meet daily transactional risks and there are specific controls in place regarding high value banking transactions.

- Financial Code 2 addresses the personal interests of staff and the Code of Conduct for local authority employees identifies the behaviours expected of all staff.

- Financial Code 5 covering financial irregularities and the prevention and detection of fraud is updated annually.

- The Audit & Risk Management Committee considers all reports by the Council's external auditors including their observations on the Council's arrangements for identifying and responding to frauds and other financial irregularities.

- Where appropriate, the S95 Officer will draw the attention of the Corporate Management Team to any significant issues relating to fraud.

- In the ordinary course of work, internal auditors consider the adequacy and effectiveness of controls which assist management to prevent and detect fraud.

- The Council's whistle-blowing policy includes access to a confidential help-line (Expolink) which allows staff to report any concerns.

- The Council has entered into an Information Sharing Protocol with Police Scotland (dated January 2015) for the purpose of assisting in the prevention and detection of serious organised crime in Public Procurement, recognising that there is an opportunity for unscrupulous, criminal or corrupt organisations and people to make criminal financial gain from Council contracts.

- The Council continues to be pro-active in the management of the risks associated with cyber-crime.

- The Council has developed a Corporate Anti-Fraud and Corruption Policy and an Integrity Group instituted that meets regularly.

3.10 Ensuring Effective Management of Change and Transformation

- The Council Plan 2018-2022, approved by Full Council in September 2017, sets out the need for change and outlines the focus for the period 2017-2022.

- As part of the 2018/19 Budget development, a Transformation programme – Delivering a Modern Council was established. At Full Council on 30 April 2018, Members agreed arrangements for the operation of the Transformation Board, based on the learning from the Business Transformation Steering Group, to have oversight of the transformation programme.

- At Full Council on 26 June 2018, Members agreed a Transformation Programme to address the challenges of providing high quality services across dispersed rural communities to an aging population, against a backdrop of addressing a significant funding gap projected for future years, reaching over £47m by 2021/22. Six Delivery Boards were established, led by Heads of Service and were instrumental in designing the Council's Budget Consultation.

- The Transformation Programme was reviewed in March 2019 and it was agreed by Full Council in March 2019 that the transformation work needed to have increased focus and tempo to address future fund gaps. CMT now

meets fortnightly with the Transformation programme being a focus every second meeting; and Heads of Service leading Transformation Themes.

- The Transformation Programme clearly sets out the context in which the Council is likely to be operating in the future, the main themes of the modernisation programme and the delivery arrangements, including timelines. Roles and responsibilities for leadership and direction are clearly set out with managers and resources allocated to all themes and workstreams.

- The Council supports the delivery of change, improvement, and transformation across the organisation by focusing on Council Priorities and deploying a range of approaches to support the identification and delivery of opportunities to improve quality and transform services to meet these. These include using self-evaluation through PSIF; system and business process reviews, using lean approaches; service review programmes; implementing major business change projects; and benchmarking for improvement. Priority areas of change and transformation will be around automation – making the best use of technology to allow customers to self-serve as far as possible, smarter working – improving the way we operate by reducing the number of offices, making it more flexible for use and by encouraging flexible working by staff and through sharing services – working in collaboration, identifying and exploring opportunities to deliver services differently, in partnership with public bodies, empowering and enabling communities and through sharing services with other partners, with the aim of achieving efficiencies and innovation.

- These arrangements enable the effective management of a range of related transformation projects, including service reviews, ensuring:
  - risks are managed appropriately;
  - relationships between individual projects are understood and managed;
  - individual projects, and the overall programme, is delivered within the constraints of time and budget;
  - issues that are common across all individual projects (for example communication and staff engagement) are completed once;
  - those outcomes that are planned are actually achieved.

- The Council has a robust Budget Development process in place through which the Corporate Management Team addresses the main financial challenges of the Council. The process recognises the pivotal role of Members in setting the policy direction relative to achieving efficiencies and budget savings and is reviewed annually by the Full Council.

- Our Council's Workforce Charter sets out the vision and accountabilities of our leadership, managers and staff setting out the guiding principles by which all our people will work together as One Council to meet the Priorities through to 2020 and beyond.

- Our Councils Workforce Strategy continues to be implemented and adapted to revises Council Priorities and sets out our workforce agenda within four key themes including; planning effectively for our Council's future needs (workforce and succession planning focus, an effective policy framework, best

practice standards and measurable outcomes); Improve employee engagement; we are openly participating and engaging with our staff more than ever; our staff recognise the work they do towards Council Priorities, open and clear communication and improving health and wellbeing; Enabling our employees to succeed, right skills, ability and knowledge to undertake new or revised roles; be a learning organisation and embed performance management and learning plans, build transferrable skills and support young people in finding employment; Ensuring equality for all; implement the Living Wage, have a zero tolerance to discrimination, harassment and victimisation.

- A Management Development Programme for 2018/19 designed to upskill middle managers, make them more effective in delivering services and supporting our workforce has been implemented. The Development Programme covers a wide range of competencies including leadership, people management and budget management. Inter-agency training in community participation and engagement continued during 2018/19 and there is now over 120 Council officers with a shared understanding and up to date skills.

- To support transformation we need a fit, healthy and engaged workforce and the delivery of our strategic Health and Wellbeing Strategy sets out key aims to support our workforce, builds resilience to cope with change and reduces sickness absence and increases productivity.

- Workforce planning arrangements are embedded within Directorates and supported through our HR Business Partnering arrangements and HR metrics are being used to support workforce planning decisions.

- Our Council has set up a Workforce Transition Board as part of the Transformation Programme which looks at workforce planning, voluntary severance and wider strategic workforce issues. The aims are to help to secure budget savings, create upskilling and development opportunities for staff and to help facilitate and create workforce change with a vision to support the development of a workforce fit for the future.

- Strategies and policies have been developed and improved to support transformation and are aligned to the Council Plan priorities including redeployment, matching and voluntary early retirement and redundancy and the implementation of our DGTransform programme.

- The Council and NHS D&G continue to implement an integrated workforce and organisational development strategy.

3.11 Ensuring the Authority's Financial Management Arrangements Conform with the Governance Requirements of the CIPFA Statement on the Role of the Chief Financial Officer in Local Government (2010) and the Local Authority Accounts (Scotland) Regulations 2014 and, where they do not, Explain Why and How They Deliver the Same Impact

- The Head of Finance & Procurement is authorised as Proper Officer (S.95 Local Government (Scotland) Act 1973) for the administration of the Council's

financial affairs and his role is outlined in the Council's Scheme of Delegation to Officers. He is a member of the Corporate Management Team.

- The system of internal financial control is based on a framework of regular management information, financial regulations, administrative procedures (including segregation of duties), management supervision and a scheme of delegation and accountability. The system is maintained and developed by officers within the Council and includes:
  - comprehensive budgeting systems;
  - regular reviews of periodic financial reports that measure financial performance against forecasts;
  - targets against which financial and operational plans can be assessed;
  - preparation of regular financial reports which compare expenditure with plans and forecasts;
  - clearly defined capital expenditure guidelines;
  - formal project management disciplines.

- The Council's financial management arrangements conform to the governance requirements of the CIPFA Statement on the Role of the Chief Financial Officer in Local Government (2010).

3.12 Ensuring the Authority's Assurance Arrangements Conform with the Governance Requirements of the CIPFA Statement on the Role of the Head of Internal Audit (2010) and, Where They Do Not, Explain Why and How They Deliver the Same Impact

- The Council's Internal Audit Service operates in compliance with the CIPFA Code of Practice for Internal Audit in Local Government. A revised internal audit charter was approved by the Audit & Risk Management Committee in December 2013. The internal audit charter provides the necessary authorities for internal audit to have access to all records and assets of the Council, for it to operate independently in accordance with professional standards, and to have all necessary access to report its findings to the appropriate level of management as it determines. These arrangements conform to governance requirements in the CIPFA Statement on the Role of the Head of Internal Audit.

3.13 Ensuring Effective Arrangements Are in Place for the Discharge of the Monitoring Officer Function

- The Chief Executive, the Monitoring Officer (Head of Legal and Democratic Services), The Section 95 Officer (Head of Finance and Procurement) and the Proper Officer (Director Corporate Services) meet monthly to consider and recommend action in connection with current governance issues and other matters of concern regarding probity.

- In carrying out any enquiries, the Monitoring Officer has unqualified access to any information held by the Council and to any employee who can assist in the discharge of her functions. As part of the new management structure, the Monitoring Officer will have two Deputies, Legal and Licensing Manager and the Democratic Services Manager who will act when the Monitoring Officer is absent from the office or considers herself to have a conflict of interest.

- Following consultation, in particular with the Chief Executive, the Monitoring Officer reports to the Council from time to time on such matters of corporate governance or relating to the ethical standards framework as, in her opinion, require review.

- In December 2016 the Monitoring Officer presented a Monitoring Officer Protocol to Full Council to outline how she would perform her duties in a way that reflected legal requirements and best practice.

3.14 Ensuring Effective Arrangements are in Place for the Discharge of the Head of Paid Service Function

- Delegations to the Chief Executive are set out in the Council's Scheme of Delegation to Officers. The Scheme has been reviewed and revised, and is subject to regular review.

3.15 Undertaking the Core Functions of an Audit Committee, as Identified in CIPFA's Audit Committees: Practical Guidance for Local Authorities

- The Audit & Risk Management Committee at its meeting on 30 October 2014 noted revised guidance from CIPFA on the function and operation of Audit Committees. The remit of the Committee was expanded to include (1) preparation of an annual report on the work and performance of the Audit and Risk Management Committee; and (2) a role in the development of the Council's Code of Corporate Governance and Annual Governance Statement in advance of it being submitted for approval to Policy and Resources Committee; and (3) provision of an independent assurance on the integrity of the financial reporting and annual governance processes.

3.16 Ensuring Compliance with Relevant Laws and Regulations, Internal Policies and Procedures, and that Expenditure is Lawful

- The Council's decision-making structure includes Schemes of Delegation, Standing Orders, Financial Regulations and Procurement Standing Orders.

- The Monitoring Officer fulfils her duty to report on any proposal, decision or omission by the authority or any committee, joint committee or employee of the authority which has caused or would be likely to cause a contravention of the law or a code of practice.

- The Internal Audit charter in the Audit Committee handbook includes in its remit that Internal Audit will review management's achievement of the following business objectives:
  - Effective and efficient operations
  - Reliable internal and external reporting
  - Compliance with laws, regulations and internal policies.

- The Council's Financial Regulations state that financial transactions are not permitted unless they fall within the legal powers of the Council and are within the limits set by the Council.

- New Procurement Standing Orders were agreed by Full Council in March 2017. Procurement activity and compliance is now reported quarterly to Policy and Resources Committee.

- The Council has internal legal resources and uses external legal resources for complex issues on which particular expertise is required.

3.17 Whistleblowing and for Receiving and Investigating Complaints from the Public

- The Council has an Expolink Hotline in place where employees wish to flag up serious issues anonymously.

- The Council has implemented the national 2-Stage Complaints Handling Procedure for Council's services. A review of this procedure is currently ongoing.

- The Council publishes an Annual Complaints Monitoring Report each year as required by the Scottish Public Services Ombudsman (SPSO). The report is made available online on the Council's website and in hard copy in Customer Service Centres.

3.18 Identifying the Development Needs of Members and Senior Officers in Relation to their Strategic Roles, Supported by Appropriate Training

- Following elections in May 2017, Full Council agreed the Members' Training and Development Programme 2017/18 and during 2018/19 this programme has included community engagement and poverty awareness., Members also have open access to a range of training and Continuing Professional Development (CPD) events on an individual basis. Members are supported in identifying their training and CPD needs by a dedicated Learning and Development Officer based in Lifelong Learning. Members requirement for a more flexible approach to accessing training is an action for 2019/20. Complementary to the formal programme, is a series of briefing events and seminars on new legislation and policies e.g. Community Asset Transfer, Community Participation and Engagement; developing our new Waste Strategy; and there are Members Seminars to inform the Directorate Business Plans.

- Our Council embraces the Improvement Service CPD programme for Elected Members. Members have the opportunity to self and peer group assess themselves against the skills profile of their role using 360º appraisals. From the results of this assessment, and following feedback, Members can then opt to follow an online based development plan.

- All Council officers participate in the Council's annual performance development review programme. Each Officer therefore has Objectives which are linked to the Council's business needs and Priorities and their Directorate Objectives.

3.19 Establishing Clear Channels of Communication with all Sections of the Community and Other Stakeholders, Ensuring Accountability and Encouraging Open Consultation

- During 2018/19 the Communities Committee and Directorate has progressed a number of community empowerment issues including:

- Implementation of the Community Participation and Engagement Strategy and agreement of a Framework – including a requirement for Consultation Mandates to be agreed, detailing the methodology and costs of any engagement activity
- Implementation of the Community Asset Transfer Strategy and agreement of an Appeals Sub Committee including our first Annual Report which evidenced 14 transfers
- Implementation of the Volunteering Strategy, including our first 'Volunteer Agreements'
- Implementation of the Participation Request Strategy – including our first Annual Report
- Implementation of the Participatory Budgeting Framework – including the introduction of online voting and Evaluation of our first two PB Exercises
- "Community Conversations" - discussions with communities about the services within 'Streetscene' (e.g. grounds maintenance, burials, road cleansing)
- Allocation of £250k Tackling Poverty budget to assist in 'Making Ends Meet' and Child Poverty with the allocations made at Participatory Budgeting events
- support for a Reference Group of volunteers who have with lived experience of poverty; and a Co-ordination Group which involves CP partners and the Reference Group volunteers
- A Commission on Representation and Engagement (Third Sector and Protected Characteristics) which has identified and delivered on co-produced Outcomes
- Updating of Ward Profiles, giving key data for each of our 12 Wards
- Holding our first series of Ward Events which were proposals from members of the local community to discuss issues with their Elected Members on a range of topics including road safety, education, waste and a Question Time event with a secondary school. Reports will come to the relevant Council forums in autumn 2019 on the feedback on the first set of Events; and the Actions agreed at them
- Agreement in December 2018 of an inter-agency programme of engagement with communities, to avoid consultation fatigue and make best use of partners' resources in carrying out the engagement.

- The NHS, D&G has established a Participation and Engagement Network (a voluntary citizens panel) which is open to all partners to use.

3.20 Enhancing the Accountability for Service Delivery and Effectiveness of Other Public Service Providers

- The Local Outcomes Improvement Plan was agreed by the Community Planning Partnership in November 2017. Robust monitoring and reporting arrangements (involving a range of Council senior officers and community groups) have been developed and the first Annual Report will be published by 1 October 2018 as required by the Community Empowerment (Scotland) Act 2015.

3.21 Incorporating Good Governance Arrangements in respect of Partnerships and Other Joint Working as identified by Audit Scotland's Report on the Governance of Partnerships, and reflecting these in the Authority's Overall Governance Arrangements

- Partnership arrangements, particularly their governance arrangements, are agreed by the relevant Service Committee. The Partnership arrangements are drawn up following Scottish Government or professional association guidance and/or using best practice from other Councils and partnerships.

- The Community Planning Partnership has an Operating Protocol which is kept up to date and which details the memberships, remits and communications arrangements of CP groups.

- There is a Dumfries and Galloway Good Partnership Guide promoted to local partnerships which draws on Audit Scotland and PSIF checklists.

- The Community Planning Partnership has an Improvement Plan in place which sets out specific actions to improve our arrangements; and Risk Register, both of which are updated each year.

- During 2018/19 the Community Planning Partnership has contributed to national work around the Local Governance Review; and the CP Manager (currently the Chair) shares practice and learning from other CPPs from the Scottish Community Planning Network.

- A Review of locality partnerships is underway and is due to report recommendations by September 2019, reflecting new Third Sector Area Partnerships and Roadshows, introduced in November 2018, and other locality developments.

4. Review of Effectiveness

4.1 The Council continuously reviews the effectiveness of its governance arrangements. Senior Management arrangements have been strengthened with the strategic focus placed on the Corporate Management Team (CMT) which now includes Heads of Service and during 2018/19 met monthly. The Senior Leadership team comprising the Chief Executive and the four Directors met weekly and a Heads of Service Group met monthly during 2018/19. These arrangements ensured that all aspects of the Council's governance arrangements are considered by an appropriate management group through their respective work programmes. Elected Members are central to the Council's governance arrangements and there is a healthy culture of questions and challenge, evidenced by some modernisation and increased transparency in recent years.

4.2 The Internal Audit function within Dumfries & Galloway Council is responsible for independent appraisal of the Council's systems of internal control (including risk management). The work undertaken by Internal Audit during 2017-18 was based on the assessment of risks and was communicated to those charged with governance through the annual plan.

4.3 Internal Audit communicates its findings through reports to operational management. These reports are also reviewed by the Audit, Risk and Scrutiny (the successor to Audit & Risk Management Committee and incorporating Scrutiny), particularly in respect of the effectiveness of Internal Audit's work and the adequacy of management's response. The recommendations in Internal Audit's reports are tracked and reported through to completion to provide assurance that necessary control improvements have been implemented by management.

4.4 The priority work for the Internal Audit section is a 3-year programme of assurance testing on the main financial systems of the Council.

4.5 The Council's egenda committee management system was changed to 'ModernGov' during 2018/19 to give Members a more effective system so that they can see the forward plan of the Council business anticipated at strategic, service and area committees

5 Agreed Areas for Improvement 2018/19

The areas for improvement for 2018/2019 are listed below with progress. Some of these areas for improvement will continue to be of focus in 2019/20.

Responding to Inquiry Recommendations

Members will oversee the responses to the Independent Inquiry. The initial report on how recommendations will be addressed will be brought for consideration by Members to Full Council in June 2018.

- Business as usual and regular reports to Full Council. Should be completed in September 2019.

Elected Member Training

Build on the work of 2017 and further improve and develop the training programme for Elected Members in the new Council.

- This is continuous, however new developments will be progressed as improvement in 2019/20.

Modernisation Programme

At Full Council in February 2018, Members agreed the themes of the Modernisation Programme to transform how we deliver services and close the budget gap in future years.

- New Transformation Programme agreed March 2019 and ongoing.

Integrated Joint Board – Governance Arrangements

Work has commenced jointly with the NHS and will continue during 2018/19 to ensure that governance arrangements that are in place are followed and clearly understood by Elected Members and Officers; and where there are gaps, or where governance can be strengthened, action is taken.

- Good progress made during 2018/19 and work will continue in 2019/20.

Review of Complaints

A review of the Complaints System will be undertaken to try and ensure that there is a focus on solving problems rather than following process and procedures. This will

take place following the restructure of the Information Management and Complaints Unit.

- Completed.

Homelessness
The Council will continue to implement its Improvement Plan, recognising the importance of multi-agency working.

- Good progress made and this will now be regarded as business as usual with regular reporting to Committee.

Local Code of Corporate Governance
Review and revise the Local Code of Corporate Governance.

- Completed.

6 Improvement Areas for 2019/20

Elected Member Training
Build on the work of the previous two years and provide more focused training based on particular and specialist needs.

Transformation Programme
At Full Council in March 2019, a more focused Transformation Programme was launched. This will be a prime focus for Senior Officers and Members this year.

Integrated Joint Board – Governance Arrangements
Good progress was made during 2018/19 both by the IJB and the Council in improving reporting, Member awareness and training. This will continue during 2019/20 with the Council's new committee structures and defined reporting based on delegations to Full Council and the new Social Work Services Committee.

Public Engagement in Budget Process
Members wish to develop a budget process for 2020/21 with improved public engagement

The Best Value Audit Improvement Plan
Officers are delivering the Best Value Improvement Plan actions and will continue to do so and report progress during 2019/20.

Community Councils
The implementation of the Development Programme for Community Councils includes improvements to the Enquiry Service; implementation of the Amended Scheme of Establishment; and supporting them to fulfil their statutory duty of local engagement and representation to public bodies

- Community Council Elections in October 2019

Conclusion

On the basis of the review of governance arrangements for 2018/19, it is confirmed that the Council has continued to focus on its Priorities and Commitments; it has put processes in place to achieve them; it has worked with its partners to achieve a common purpose in delivering outcomes for its citizens and service users, notwithstanding a challenging budget environment; it has sought to demonstrate the

principles of good governance in the behaviours of its Elected Members and Officers; in consultation with local people it has made informed and transparent decisions which are subject to effective scrutiny; it has managed its risks effectively; it has responded appropriately when performance has not been adequate; it has received a positive Best Value Assurance Report; and it has ensured Elected Members and Officers, within the financial resources available, have the capacity and capability to deliver its purpose effectively.

We are therefore satisfied that the Council has in place appropriate arrangements for the governance of its affairs and that reasonable assurance can be placed on the adequacy and effectiveness of the Council's corporate governance systems in the year to 31 March 2019.

Signed:

Elaine Murray, Leader,
Dumfries & Galloway Council

Gavin Stevenson, Chief Executive,
Dumfries & Galloway Council