Dumfries and Galloway
IJB Audit and Risk Committee

9th September 2021

This Report relates to
Item 8 on the Agenda

Internal Audit Annual Report

Paper presented by Julie Watters

For Discussion and Noting

Author:	Julie Watters, Chief Internal Auditor, Integration Joint Board Julie.Watters2@nhs.scot
List of Background Papers:	
Appendices:	**Appendix 1** – NHS Internal Audit Annual Report 2020/21 **Appendix 2** – NHS Governance Statement 2020/21 **Appendix 3** – DGC Draft Governance Statement 2020/21

1. Introduction

1.1 The purpose of this report is to update Audit and Risk Committee on Internal Audit assurances for the Integration Joint Board (IJB) for the year 2020/21.

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 2020/21 and provides the Chief Internal Auditor's opinion on the internal control environment within the Integration Joint Board for the financial year 2020/21.**

3. Background and Main Report

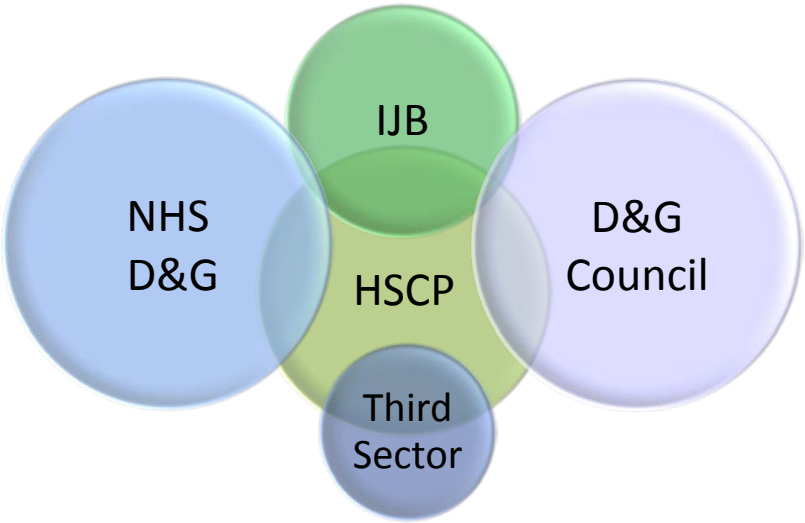
3.1 The Scottish Government Integrated Resources Advisory Group (IRAG) issued "Guidance for Integrated Financial Assurance" in support of the Public Bodies (Joint Working) (Scotland) Act 2014.

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 to inform on the overall adequacy and effectiveness of the framework of governance, risk management and control and the preparation of the governance statement.

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

Diagram 1 – Integrated Assurances



3.5 The internal audit plan, as in previous years takes into consideration the operational delivery of services within the Health Board and Local Authority on behalf of the Health and Social Care Partnership as directed by the IJB, and the annual report relies on the assurances delivered by the separate internal audit plans completed during each year.

3.6 In 2019/20, the plan included an allocation of resource from both the NHS and Council audit functions to deliver a joint audit which following discussion was agreed to focus on Delayed Discharges. Unfortunately this work was not progressed due to service pressures around the Covid 19 pandemic.

3.7 These pressures carried into 2020/21 and despite no IJB specific internal audit reviews having been undertaken during the course of the year, audit work carried out within each of the host organisations has been considered in preparing this annual report. Assurances this year have been provided verbally by the Internal Audit Manager for Dumfries and Galloway Council.

3.8 Consideration of these assurances was 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 an opinion on the IJB's internal control framework for the financial year 2020/21.

NHS Dumfries and Galloway – Assurances considered

3.9 During 2020/21 the NHS Internal Audit function reported on 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
Contract Management	Moderate	8
DLs and Scottish Government Guidance	Moderate	8
Feedback Management (incl Complaints)	Moderate	12
Remote Working	Moderate	7
Risk Management	Limited	24
Property Transactions	Significant	-
Financial Governance	Significant	4
Water Quality	Significant	9
Board Policy Framework	Limited	21
Laptop theft assurances	Moderate	9
Externals – activity monitoring	Moderate	11

3.10 All of these audits give an indication on the control environment within the IJB to some extent given that staff and processes that sit within the NHS are delivering on the objectives of the Health and Social Care Partnership, however some will have more relevance than others. This information was reported in the Internal Audit Annual Report to the Health Board's Audit and Risk Committee in June 2021. This is attached at **Appendix 1** for information.

3.11 The Health Board has a structured process for preparing the Governance Statement which collates assurances from across the relevant areas of governance. This statement has been reviewed in full along with supporting evidence as part of NHS

reporting requirements and is attached in **Appendix 2**.

Dumfries and Galloway Council – Assurances considered

3.12 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, audit work undertaken by DGC should be considered as this provides 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.

3.13 The Annual Report of the Council's Internal Audit Manager which includes his Controls Assurance Statement is being prepared for the Council's Audit Risk and Scrutiny Committee meeting on 21st September. Therefore as this has not been through the full Council committee process it cannot be shared at this stage.

3.14 The Council's Internal Audit Manager has provided a verbal update on work undertaken within the Council which confirmed that no issues of relevance have been raised from audit work undertaken.

3.15 The Council's draft Governance Statement **(Appendix 3)** has also been considered to understand where assurances are given relating to integration and joint working. In previous years the statement has made 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 2019/20. In a number of sections the Governance Statement details how this has been enhanced.

Assurances specific to the Integration Joint Board

3.16 There have been a number of meetings between the Chair and Vice Chair of the IJB Audit and Risk Committee, the Chief Finance Officer 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 Partnership and IJB.

3.17 A specific Joint Internal Audit Priorities meeting took place in January 2021. It was agreed at this meeting that a memorandum of understanding or joint working protocol would be created. This is currently being worked through, giving consideration to each Internal Audit functions obligations to their respective organisations and differing reporting obligations and timescales. It is important that this fully reflects the responsibilities that sit within the partner organisations and does not dilute the assurance expectations within the NHS and Local Authority. This will be brought to the next Audit and Risk Committee meeting to reflect relevant governance processes within the Council or NHS.

3.18 Previously, 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, 8 have formally been closed off with 1 remaining outstanding. The table below details the Management Action Plan from this audit detailing the background to this action.

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

3.19 This action, which is nearly 4 years old, 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, however this now needs to become an area that informs all other processes as the strategy is aspirational and at danger of being disconnected from other processes.

3.20 The Governance Statement for the IJB has been considered. This details the business of the IJB and its committees during the course of the year, the impact of Covid 19 on governance and the key risks that face the IJB.

4. Conclusions

4.1 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 that the Accountable Officer has implemented a governance framework in line with required guidance sufficient to discharge the responsibilities of this role.

4.2 The 2020/21 Internal Audit plan has been delivered in line with the Public Sector Internal Audit Standards.

5. Resource Implications

5.1 For 2020/21 resources were identified from within the Health and Local Authority internal audit functions. Although a joint audit was not undertaken, some of this resource was used to deliver on joint assurances for the IJB.

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 and Risk Implications

7.1 There are a number of limitations to any audit plan delivered in that the risk register

for the IJB which should be used to inform the plan is still under review. 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 year-end 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 All acronyms must be set out in full the first time they appear in a paper with the acronym following in brackets.

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**

NHS Dumfries and Galloway

Meeting:	**Audit and Risk Committee**
Meeting date:	**21 June 2021**
Title:	**Annual Internal Audit Report 2020/21**
Responsible Executive/Non-Executive:	**Jeff Ace, Chief Executive**
Report Author:	**Julie Watters, Chief Internal Auditor**

1. Purpose

This is presented to the Board for:
- Assurance

This report relates to:
- Internal Audit

This aligns to the following NHSScotland quality ambition(s):
- Safe
- Effective
- Person Centred

Please select the level of assurance you feel this report provides to the board/committee and briefly explain why:

Significant		Moderate	X	Limited	
None		Not yet assessed			

Comment:
The annual opinion is explained in the narrative of the report.

From the list below, please select which Board Priority this paper relates to. If none of the priorities suit, please select other and briefly explain why this paper needs to be reviewed at Board/Committee:

COVID-19 Containment Work		Continued Support for Staff Wellbeing	
Delivery of Sustainable Service Models		Delivery of Enhanced Services to address Pandemic Harms	
Other (please explain below)	X		

Comment:
The Internal Audit plan is informed by all NHS Dumfries and Galloway's corporate objectives and priorities and considers the risks that may impact on their achievement.

2. Report summary

2.1 Situation

This Annual Report presented to Audit and Risk Committee provides an overview of the outcomes of the 2020/21 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.

2.2 Background

Internal Audit activity covers all 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

2.3 Assessment

Based on our work throughout the year, Internal Audit has 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 2020/21 Internal Audit plan has been delivered in line with the Public Sector Internal Audit Standards.

2.3.1 Quality/ Patient Care

There is no direct impact on quality of care (and services) from the findings in this report.

2.3.2 Workforce

There are no direct workforce implications as a result of this report.

2.3.3 Financial

There are no direct financial implications as a result of this report.

2.3.4 Risk Assessment/Management

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.

2.3.5 Equality and Diversity, including health inequalities

Whilst a full impact assessment has not been undertaken, Equality and Diversity issues are fully considered during the audit planning process and as each audit is undertaken.

2.3.6 Other impacts

None identified.

2.3.7 Communication, involvement, engagement and consultation

Whilst this paper considers feedback received during the course of the audit year it provides an independent opinion on the risk management, governance and internal control framework within the Board.

2.3.8 Route to the Meeting

This paper is a direct report to the Audit and Risk Committee and is not reviewed outwith.

2.4 Recommendation

Assurance – This report summarises the work undertaken by Internal Audit to provide assurance and an independent opinion on the internal control environment within the Board for the 2020/21 financial year.

3. List of appendices

The following appendices are included with this report:

- Appendix 1, Annual Internal Audit Report 2020/21

Appendix 1

Annual Internal Audit Report 2020/21

Contents

Appendices

1. INTRODUCTION

1.1 Introduction

This Annual Report presented to Audit and Risk Committee provides a formal overview of delivery against the 2020/21 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 2020/21.

This report has been structured to:

- Summarise assurances gained from the Internal Audit plan,
- Draw attention to areas of particular relevance through audit opinions and assurances gained,
- Summarise Internal Audit activity for 2020/21 and include performance indicators, and
- Provide the Chief Internal Auditor Opinion for 2020/21

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."* *PSIAS*

Internal Audit activity covers all 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 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.

The Audit Charter was revised and presented to Audit and Risk Committee for approval in January 2020 along with the 2020/21 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. 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, therefore avoiding duplication.

2. ASSURANCE REPORT

2.1 Audit Plan 2020/21

The Internal Audit Plan for 2020/21 was approved at Audit and Risk Committee in January 2020.

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

The coverage of the plan always intends to provide assurance on whole processes, with testing being undertaken across large samples within the Board. This highlights interdependencies and reliance across services and directorates which can become more fragile as resources are stretched. This is a more effective use of audit days which results in more meaningful information coming through in the audit reporting.

Internal Audit have completed 5 audits from the 2020/21 plan to reporting stage. This is in addition to the finalisation and reporting of 5 audits from the 2019/20 plan and the undertaking of an unplanned audit in relation to procurement and security of IT equipment through the last year.

The following table indicates all reports that have been issued since 1 April 2020 and therefore have supported the assurances gained during the 2020/21 audit year.

Audit		Assurance
A/02/19	Contract Management	Moderate
A/01/20	DLs and Scottish Government Guidance	Moderate
A/02/20	Feedback Management (incl Complaints)	Moderate
A/03/20	Remote Working	Moderate
RM/01/20	Risk Management	Limited
F/01/21	Property Transactions	Significant
FM/01/21	Financial Governance	Significant
A/07/21	Water Quality	Significant
A/02/21	Board Policy Framework	Limited
H/01/21	Laptop theft assurances	Moderate
FM/01/20	Externals – activity monitoring	Moderate

Due to year end pressures and resourcing issues we were asked to defer the Externals audit from the 2019/20 audit plan this commenced late 2020. A previous Financial Transactions audit was also rolled into the Financial Governance audit to allow for some of the recent review processes within Financial Governance to become embedded and therefore to allow for adequate transactional data for testing. This increased the scope of the audit but through the additional testing has also enhanced the assurances gained from the audit.

All of the audits completed have been used to inform the Chief Internal Auditor Opinion and are summarised in the table in **Annex 1**.

2.2 Assurances gained from Audit work

Assurance levels are based on a number of different elements to form an opinion on the audit area, but ultimately any assurance given from our audit work 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 **Annex 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 as detailed by the Scottish Public Finance manual (SPFM) to enable this information to be used to inform an overall opinion on assurance 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			
	Ltd	Mod	Sig	Comp
Contract Management		♦		
DLs and Scot Gov Guidance		♦		
Feedback Mgmt (incl Complaints)		♦		
Remote Working		♦		
Risk Management	♦			
Property Transactions			♦	
Financial Governance			♦	
Water Quality			♦	
Board Policy Framework	♦			
Laptop theft assurances		♦		
Externals – activity monitoring		♦		

Overall, the audits have delivered mixed levels of assurances which have been used to inform this year's opinion.

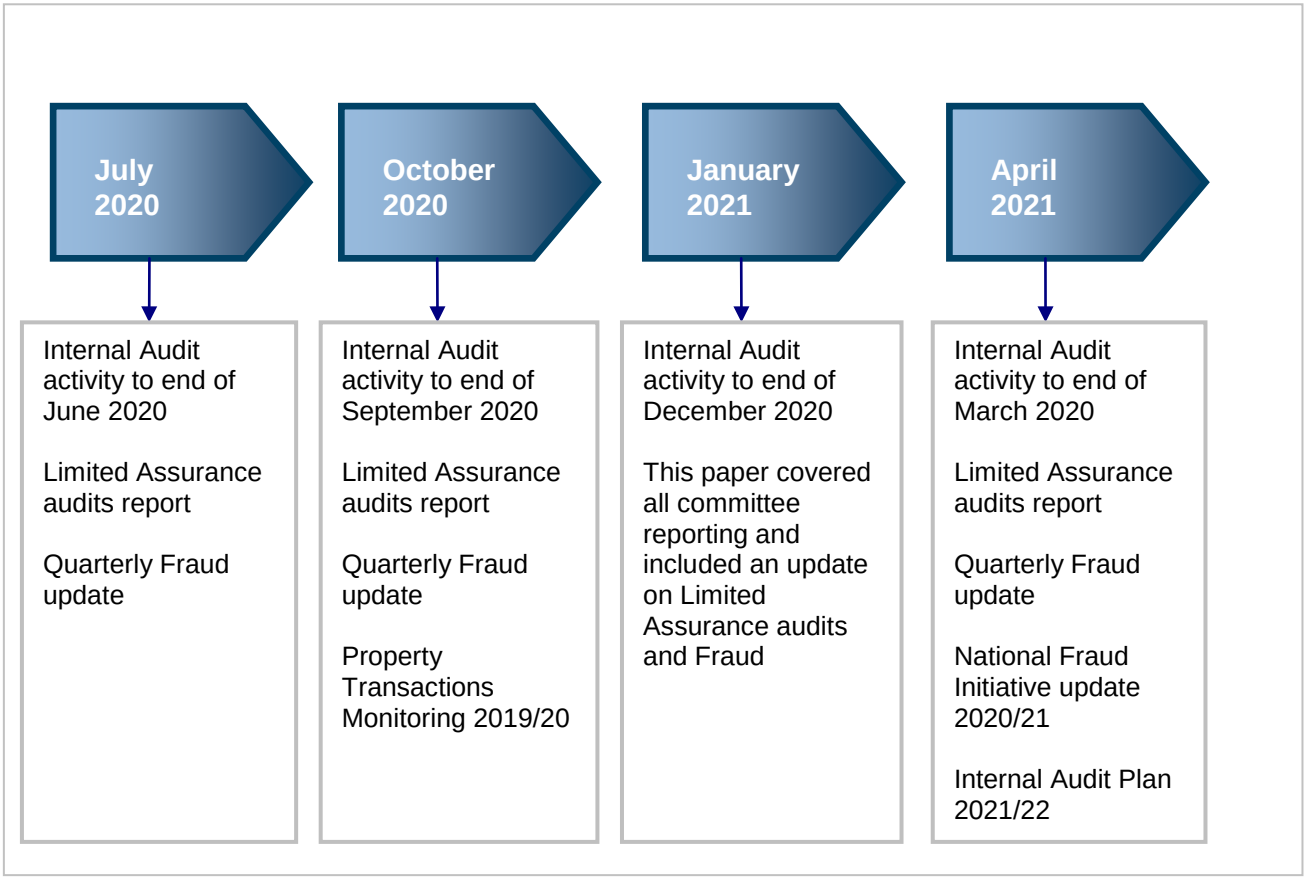
Three audits have given a Significant level of assurance, six audits have given Moderate Assurance and there have been two Limited Assurance audits reported during the year.

2.3 Reporting to Audit and Risk Committee

All audit reports are now being taken to the quarterly Audit and Risk Committee meetings as they are finalised. This is in addition to the process of Limited Assurance audits remaining a standing agenda item for the committee to ensure that the actions that require closure are reported back until they are completed so that the risks which the Board is carrying can be understood.

During 2020/21 the following reports were brought to Audit and Risk Committee by the Chief Internal Auditor.

Figure 1 – Quarterly reporting to Audit and Risk Committee – 2020/21



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. Managers are then asked to attend the next Audit and Risk Committee meeting to provide an update on progress against the actions contained within the report.

By remaining a standing item on the Audit and Risk Committee agenda this ensures 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 request further assurance from management as required.

The two Limited Assurance audits this year relate to Risk Management and the Board's Policy Framework. Risk Management was reported to the July 2020 Audit and Risk Committee meeting and the Policy Framework audit report is due to be brought to the July 2021meeting.

As has been reported in previous years, during the course of audits, the audit team continue to have some very challenging conversations with managers in relation to the areas of Risk Management, Business Continuity and the board's policy framework. It is hoped that the implementation of the actions associated with these audits will support a more robust approach in these areas moving forward and support the importance of governance in the NHS as detailed within the Governance Blueprint at a national level.

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.

2.4 Reporting to Management

The outcomes of all audits are reported to relevant local managers and Directors, 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 addressed 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.

2.5 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 position as at 1st June 2021 is detailed below.

Table 2 – Audit actions by Director

Director	Total	Overdue	Open	Pending Review
Finance	31	5	26	0
COO/Integration	41	26	15	0
Nursing	22	16	0	6
Chief Executive	13	13	0	0
Workforce	9	9	0	0
Medical	8	8	0	0
Public Health	0	0	0	0
Total	**124**	**77**	**41**	**6**

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

- June 2018 – 131
- June 2019 – 29
- June 2020 – 48
- June 2021 - 77

Of the 124 actions,

- 5 are graded A,
- 51 are graded B, and
- 68 are graded as a C.

The impact of Covid-19 on management capacity to respond to audit recommendations has resulted in an increase this year. We have had a number of discussions with managers regarding revised targets dates, but have also encouraged review of actions to identify those which may require to be prioritised to facilitate urgent changes in working practices and controls at this point in time.

Whilst there are actions that remain overdue, the status of Limited Assurance audits will remain a standing item on the Audit and Risk Committee agenda. Currently the Risk Management audit is being reported through this route supported with updates on closure of actions coming through the Strategic Risk Management update that is brought to each Audit and Risk Committee meeting.

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.

At the time of reporting, audit findings are categorised into a Finding Group and Finding Type to allow for trends in areas of control weakness to be recorded and monitored. Figures 2 and 3 below show the current 124 outstanding actions broken down by each area.

Figure 2 – Open actions by Finding Group

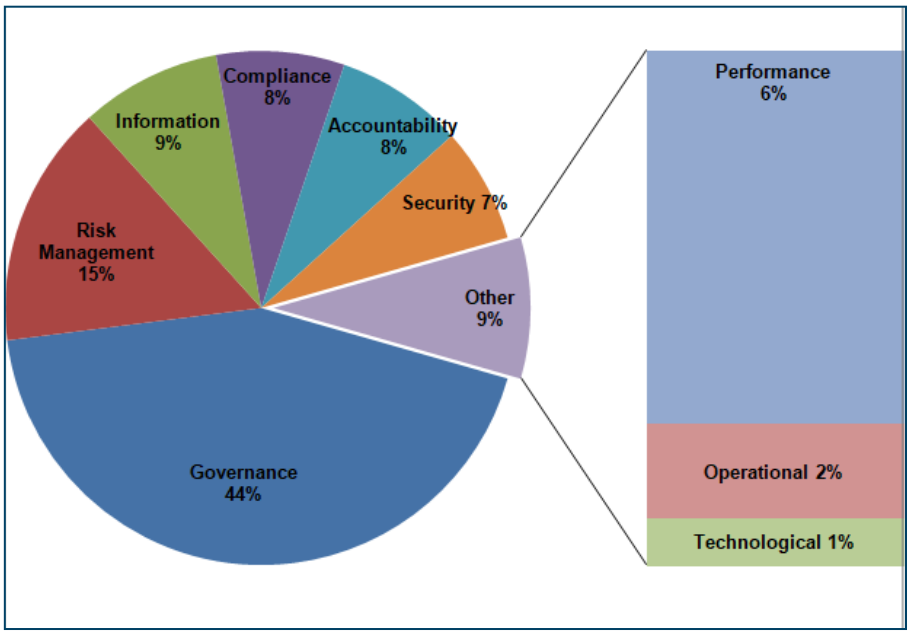
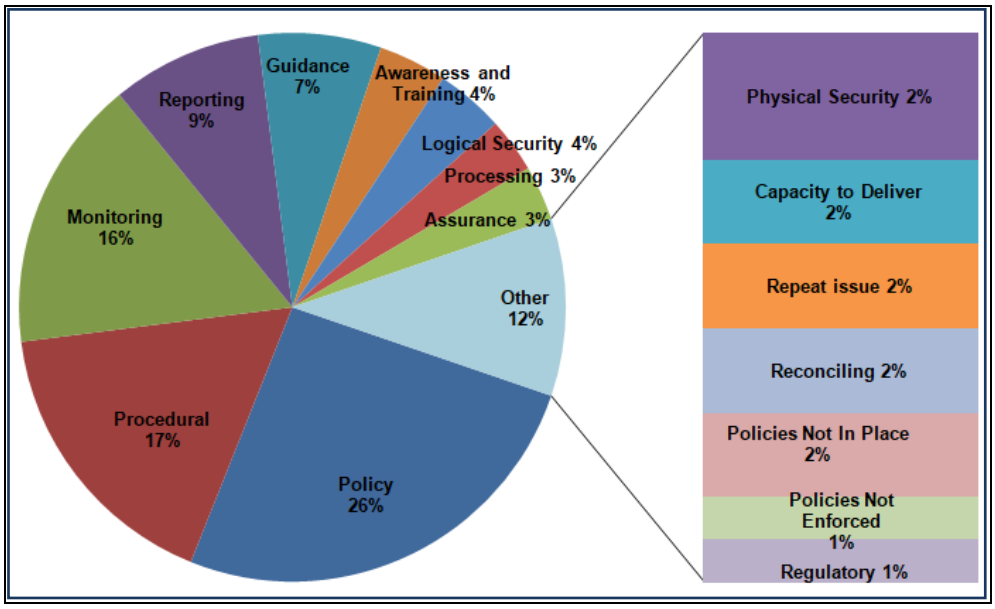


Figure 3 – Open actions by Finding Type



We can see from the figures that Governance (44%) and Risk Management (15%) issues make up 59% of the Finding Groups and that Policy (26%), Procedural (17%) and Monitoring (16%) are the main Finding Types. This is broadly similar to analysis of the three year trend of audit findings.

Further information on this can be brought back to Audit and Risk Committee should the members feels that this information may be beneficial.

2.6 Chief Internal Auditor Opinion

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 risk management, governance and internal control framework 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.

This report is therefore provided 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 2020/21 and 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.

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

2.6.1 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.

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 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 as wide a range of sources as possible within NHS Boards. Whilst not being overly 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.

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
- relevant Board documentation presented as part of the preparation process for the Governance Statement

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.

The Committee Assurance Statements have been amended to follow a template based on their relevant Terms of Reference and cover areas such as membership, quoracy, attendance and matters discussed throughout the year.

In previous audits we have made recommendations around the approval process for annual reports that we are placing reliance on for year-end processes such as Risk Management and Information Assurance where these reports should be approved through their respective groups/committees before being passed for assurance purposes. This has been taken on board although year-end processes have been different this year, and in the absence of certain groups and committees meeting, the approval of some documents has been carried out through virtual means.

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

2.6.2 Audit Assurances to support the Governance Statement

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.

- **Staff Governance**

The Workforce Director's assurance return mentions a number of challenges in relation to the impact of Covid on areas such as delivery of training and identifies a number of systems issues which may impact on the integrity of workforce data. The return also highlights the closure of all actions relating to the Internal Audit on Workforce reporting systems (eESS) which gave a Limited level of assurance.

The majority of our audit work is focussed around processes and not departments or locations therefore there have been a number of audits that have considered, and provided assurances around, Staff Governance processes. One audit was given specific focus at the early stages of Covid relating to Remote Working. This carried 7 actions and gave a Moderate level of assurance. We have received no updates on progress against any of these actions to date.

Follow up work has been undertaken on a number of audits from previous years. The Head of Organisational Development & Learning has had a number of meetings with Internal Audit to discuss progress on implementing actions and evidence that will be required to close these off. Two of these actions relate to the systems issues referred to in the Workforce Directors statement.

There are 9 outstanding actions within Workforce which are currently past their due date.

- **Financial Governance**

The Director of Finance's assurance letter 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 and where challenges have arisen during the course of the year.

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 assurances around Financial Governance. Audits that have concluded in the last year have included:

- Contract Management - Moderate Assurance (finalised in year)
- Financial Governance - Significant Assurance, and
- Externals – Moderate Assurance (to come to July meeting)

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 31 audit actions, 5 of which are overdue. This is an improvement on previous years and reflects the work that has been done in this area.

During 2020/21 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 and working within a Committee "lite" framework has been Patient Safety, Quality Improvement, Duty of Candour, feedback from various external performance reviews such as HIS and learning from adverse incidents. This is consistent with previous years.

Assurance is also provided from the Nurse Director's statement which covers, amongst others, clinical governance, quality of care, risk management and patient safety. This also recognises a positive HIS inspection.

Within the Nursing Directorate there are currently 22 open actions which are overdue. These mostly relate to Risk Management.

The Medical Director's statement predominantly covers Information Governance, with narrative around some of the key issues and improvements within these areas during the year, concluding that adequate controls are in place. There are currently 8 open actions within the Medical Directorate relating to Pharmacy, all of which are overdue. These are not mentioned within the statement.

The Chief Operating Officer assurances have been enhanced this year with the introduction of an assurance framework which gains assurance from each of the General Managers within her area around their areas of responsibility. This has been mapped into a summary sheet, which provides further detail

Audit work completed in this area includes the audit around Water Quality which gave a Significant level of assurance.

- **Information Governance**

Assurances to inform the Governance Statement in this area come from the Information Assurance Committee (IAC) annual report which comes to Audit and Risk Committee and are also covered on the Medical Director's statement.

We have reported on one audit specific to Information Assurance in relation to Laptop thefts in another board which were raised through a CFS fraud alert. This gave Moderate Assurance, in that we were able to demonstrate that we had not encountered loss of IT equipment, however the gaps in controls which had facilitated this in other Boards were also an issue here. This report carried 9 recommendations.

We have also completed an audit on Remote Working which has given a Moderate level of assurance. This audit flagged that there is a disparate approach within the Board with IM&T and HR taking on board elements of the process with no overall approach or strategy that staff are guided by. We are aware that this is now being looked at under a "Once for Scotland" approach.

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.

There are currently 17 outstanding audit actions on relation to Information Governance and IT Security. We continue to provide support to enable closure of actions and further work is required to understand why they remain open and ensure that this reporting is taken through the Information Assurance Committee. A number of these areas were picked up as areas of weakness within the external NIS Regulations audit.

- **Best Value**

How the board achieves Best Value is not overtly captured within the Governance Statement process. There is generic reference to best value within the Governance Statement

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 annual report.

- **Risk Management**

There is a requirement for an Annual Risk Management report to be prepared, which 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.

Risk continues to be governed through the Risk Executive Group with a change during the year of the creation of the Risk Oversight Group in recent months. Updates from both groups come to Audit and Risk Committee for information.

The Corporate Risk Register is currently subject to review. The Board has a Risk Appetite statement which is also due for review. Both of these areas have been the subject of recent Board workshops. Further work is needed to maintain the momentum in this area.

We completed an audit of Risk Management which was reported in July 2020 and gave a Limited level of assurance. This audit carried 24 recommendations. We are aware that the Risk Management Strategy and Policy have been reviewed and with the implementation of the audit recommendations progress should be made moving forward.

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

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 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 number 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.

Further reflection is now required on how these measures are set to consider the impact of remote working on audit approach and also availability of staff and managers to progress audits and to endure they are meaningful.

3.2 Audit Activity

The audit team continue to use the audit software system AutoAudit, 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.

The software is currently over 3 years behind on upgrades as these are no longer compatible with Windows 7, with the most recent version only running on Windows10. This has impacted on functionality with many of the added benefits of the systems now not available such as enhanced reporting tools. This means that many reports have to be created from downloads with analysis within Excel which is time consuming but unavoidable until the system is updated.

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 2020/21 carried 437 audit days based on a complement of 3 audit staff. We had successfully recruited into two vacancies for an Auditor and Trainee Auditor, both commenced in their roles mid-January 2020.

One staff member commenced maternity leave in July 2020 which mean that the available audit days was reduced to roughly 310 days. During the year 280.5 audit days were undertaken by the audit team.

This has been an unprecedented year for everyone across the organisation and audit have been mindful of the pressures that have been placed on staff due to be audited.

We have considered the changing risk profile within the Board to ensure that audit focus is on the key areas and to consider the impact of Covid on the Board's risk, governance and control framework this year.

The main elements of non-audit time are:

- Audit Development – 65.83 days (2019/20 - 64.47 days)
- Personal Development – 35.17 days (2019/20 - 100.73 days)
- Administration – 20.50 days (2019/20 - 29 days)
- Corporate Support – 9.88 days (2019/20 - 44 days)
- Follow up – 9.43 (2019/20 - 8.77 days).

As can be seen from the figures above a conscious effort has been made to minimise non-audit time where possible.

Time recorded against Audit Development and Administration includes, for example, ongoing maintenance of our audit system, review of working documents and maintenance of our Internal Audit intranet page. This has increased as we have had some issues with our AutoAudit system. As mentioned above, we have had to introduce a number of workarounds until we can get Windows 10 and Office 365 installed. This is therefore time spent by the audit team on non-audit specific tasks. There is an aim to reduce this time next year.

Personal Development includes mentoring, work-shadowing, mandatory training, internal and external courses and webinars, self-directed learning and annual development review and mid-year review processes. All mandatory training and annual reviews are currently up to date within the team.

There has been a continued focus this year in getting responses to outstanding actions on Issue Track. This requires review of each 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 9.88 days this year (44 days last year). Time allocated against this includes support to staff on completing their actions within Issue Track and dealing with ad hoc requests for support. The majority of this time is in relation to the Risk Management audit and as a need to minimise this time was identified last year this has been managed down.

Internal Audit's current KPIs are detailed in **Annex 2**.

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.

4. SUMMARY

The Chief Internal Auditor opinion is based on the work completed by Internal Audit during the year and is limited to the coverage of the Audit Plan. While all risks and areas of governance may not have been included in the plan, we have undertaken sufficient work to provide reasonable assurance that there is an adequate control environment in place. We have delivered an agile plan of work which has reflected the risks to the board, where known and considered our risk management, governance and control processes where working practices have been amended and where reporting has been through a Committee “lite” structure.

Our external auditors, Grant Thornton UK LLP, consider the work of internal audit as part of their audit process although they no longer 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 Public Sector Internal Audit Standards (PSIAS) which are the mandatory Internal Audit Standards in place for NHSScotland. 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. There have been no such issues requiring disclosure during the course of the year.

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 2020/21 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.

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 for their continuing commitment and effort during the course of what has been an extremely difficult year.

Glossary of Terms

CFS	-	Counter Fraud Services
Datix	-	Board's Risk Management system
DL	-	Directors' Letter
eESS	-	electronic Employee Support System
EQA	-	External Quality Assessment
HIS	-	Health Improvement Scotland
IAC	-	Information Assurance Committee
KPIs	-	Key Performance Indicators
PSIAS	-	Public Sector Internal Audit Standards
SFI's	-	Standing Financial Instructions
SPFM	-	Scottish Public Finance Manual

Audit Plan 2020/21 - Progress and Outcomes

									Best Value							Governance			
Ref	**Audit title**	**Assurance**	**Status**	**A**	**B**	**C**	**D**	**Total**	**Vision and Leadership**	**Governance and Accountability**	**Use of Resources**	**Performance Management**	**Effective Partnerships**	**Equality**	**Sustainability**	**Financial**	**Staff**	**Clinical**	**Information**
A/02/19	Contract Management	Moderate	Final	-	2	6	-	8	✓	✓	✓	✓			✓	✓	✓		✓
A/01/20	DLs and SG Guidance	Moderate	Final	-	3	5	-	8	✓	✓		✓		✓	✓	✓	✓	✓	✓
A/02/20	Feedback Management (Complaints)	Moderate	Final	-	7	5	-	12		✓		✓	✓	✓			✓	✓	✓
A/03/20	Remote Working	Moderate	Final	-	2	5	-	7	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓
RM/01/20	Risk Management	Limited	Final	-	8	16	-	24	✘	✘	✘	✘	✘	✘	✘	✘	✘	✘	✘
F/01/21	Property Transactions	Significant	Final	-	-	-	-	-		✓	✓				✓	✓			
FM/01/21	Financial Governance	Significant	Final	-	1	3	-	4	✓	✓	✓	✓			✓	✓			✓
A/07/21	Water Quality	Significant	Final	1	7	1	-	9		✓		✓	✓		✓			✓	✓
A/02/21	Board Policy Framework	Limited	Final	2	13	6	-	21	✘	✘	✘	✘	✘	✘	✘	✘	✘	✘	✘
H/01/21	Laptop theft assurances	Moderate	Final	1	5	3	-	9		✓	✓	✓			✓	✓			✓
FM/01/20	Externals – activity monitoring	Moderate	Prelim	-	6	5	-	11		✓	✓	✓	✓		✓	✓		✓	✓

Annex 2

Internal Audit Performance Measures – KPI's

Goals	Cost, Quality, Delivery	Measures	KPI	2020/21
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	100% of recommendations accepted
	Q	Timely closure of audit issues		
	Q	Audit feedback 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	52% completed Does not include Externals audit carried forward at management request or Laptop fraud review
	D	Audit days – Budget v Actual *based on finalised audits	To be within 10% of budget	All audits bar one have fallen out with this target which is largely attributed to remote working although some scopes were wider to consider the impact of Covid in the area under review.
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	July 2020
	Q	Personal development reviews completed within timescales	100% completed within last 12 months	All completed to timescale
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	Audit department within agreed budget

Appendix 2

A) 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.

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 are then appointed to the five Standing Committees and have the opportunity to scrutinise and challenge the Board's executive management.

In addition, as explained in the Directors report, all Board members are Trustees of NHS Dumfries and Galloway Endowment Fund and are accountable in law for discharge of the key duties of a Trustee as described in Section 66 of the Charities and Trustees Investment ("Scotland") Act 2005.

The Directors report also explains the establishment of the Integration Joint Board (IJB). Under the terms of the Public Bodies (Joint Working)(Scotland) Act 2014 the Health Board and Local Authority delegate the responsibility for the strategic planning and delivery of adult health and social care services to the IJB. The delegation of services is governed by an integration scheme agreed by both partners, details of the IJB delegated roles and responsibilities can be found within the IJB strategic plan on the website (https://dghscp.co.uk/).

The Board operates within an assurance framework which delegates specific governance functions to key sub committees, the conduct and proceedings of the Board are set out in its Standing Orders which describe how the Board in a routine year works and which matters the Board has reserved for its approval. The standard operating committees of the Board are Healthcare Governance Committee; Person Centred Health and Care Committee; Audit and Risk Committee; Performance Committee and Staff Governance Committee. You can find the Standing Orders (and other key documents) on the Board's website under the About Us section (www.nhsdg.co.uk).

The terms of reference for each of the standing governance committees are also included in the Standing Orders. At its meeting in December 2019 the Board agreed to establish a Public Health Committee. Due to the Covid pandemic this was paused and whilst an initial Terms of Reference was agreed this wasn't progressed. It is planned that this will be established during 2021/22.

In addition the Remuneration Sub-Committee which reports directly to the Staff Governance Committee is responsible for ensuring the application and implementation of fair and equitable systems for pay and for performance management on behalf of the Board. 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 guidance, determined by the Remuneration Sub-Committee. This continued to operate during the pandemic and no significant issues were identified.

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 group met four times this year and have been assured in all areas of information governance over this period.

Temporary Governance Framework

On the 16th March 2020 agreement was given to suspend the Board Governance Committees due to the impending threat of COVID-19 and the lockdown restrictions that were being proposed and ultimately implemented. NHS Dumfries and Galloway instigated the major incident command and control structure to deal with the impending emergency and to implement the service changes that were required to be put in place to minimise the spread, impact and mortality of the pandemic on the population of the region.

The following sets out the temporary governance changes agreed by NHS Board during the year taking account of the guidance received from Scottish Government throughout:

NHS Board Meeting Date	Temporary Governance Changes agreed
6th April 2020	• Due to the restrictions with meeting in groups, NHS Board Meetings were closed to the public and the meetings were conducted electronically via Microsoft Teams with immediate effect. • All Board governance committees were suspended and any urgent items that would normally have gone to the committee were taken through NHS Board for review or a decision.

NHS Board Meeting Date	Temporary Governance Changes agreed
	• NHS Board meetings moved from bi-monthly to fortnightly to ensure that NHS Board Members were fully aware of the current impact of the pandemic. • Whilst ensuring that all of the key items that would normally be taken to Board to meet the legislative and regulatory requirements would still be added to the agenda, the key focus point would be around COVID and providing the most up to date information to NHS Board Members. • Quoracy levels for NHS Board were adjusted to reflect the current situation, with the quoracy levels moving from the Chair, 2 Executive Directors and 5 Non-Executive Members, to the Chair, 2 Executive Directors and 3 Non Executive Members. • NHS Board accepted an amended governance format to NHS Board meetings, which meant that more verbal updates rather than formal papers would be accepted. • Acknowledgement of the Command and Control structure that had been implemented as part of the Major Incident arrangements.
25th May 2020	• Decision to move to monthly NHS Board meetings, rather than the fortnightly meetings with effect from 1st June 2020. • Re-establishment of the Audit and Risk Committee, Healthcare Governance Committee and Staff Governance Committee, which would also include the Remuneration Sub-Group as from 1st June 2020 on a governance lite format similar to the one introduced at NHS Board. This was to recognise the challenges with workload and capacity within the Board, whilst acknowledging that NHS Board needed assurance on the appropriate management and delivery of health services at each stage of the pandemic. • Revisions were made to the members of the Board Governance Committees and presented to Board for noting. • Quoracy levels for the Board Governance Committees that had been re-established was reviewed and agreed to remain at 50% of the membership.
10th August 2020	• Proposal to make the Board Meetings more accessible to the public by recording the meetings was put on hold as a Once for Scotland approach to public accessibility to meeting during the pandemic was being developed. Agreement was given to maintain the current arrangements until notice of the national guidance was received.
7th October 2020	• Continue with the monthly meetings until the end of March 2021. Reviewing the arrangements for 2021/22 in January 2021. • There was a delay in receipt of the national approach to public accessibility to the meetings, therefore, agreement was sought from both Scottish Government and NHS Board members to record the public Board meetings from November 2020 and upload the recording to the website as soon after the meeting concludes as possible.

NHS Board Meeting Date	Temporary Governance Changes agreed
	• Person Centred Health and Care Committee for formally disbanded as a Board Governance Committee, recognising that there is still a requirement to have a platform for discussing various topics, including update on the volunteers programme. • Quoracy levels for NHS Board were reviewed and NHS Board members agreed that the levels should be amended from the Chair, 2 Executive Directors and 3 Non-Executive Members, to the Chair, 2 Executive Directors and 4 Non Executive Members. • Further revisions were also made to the committee membership following the resignation of one of the Non Executive Board Members in summer 2020. • The re-establishment of the Performance Committee was discussed and it was agreed that this committee would remain stood down for the time being with any essential items that would normally be taken through committee, would be reviewed and a decision made on them, if required, at the In Committee Board Meetings.
1st March 2021	• Healthcare Governance Committee to return to full governance arrangements from 1st March 2021.

The Cabinet Secretary for Health and Sport wrote to NHS Scotland on 17th May 2020 extending the professional accountability of Nurse Directors in Territorial Boards to include the need to ensure appropriate professional and clinical oversight of care homes and care at home services during the Covid pandemic for the period 18th May 2020 to 30th June 2021. As a result of this the Board set up a Care Home Oversight Group, initially meeting daily. This group continue to operate and now meets on a twice weekly basis. A paper was presented to Board in August 2020 which set out the governance and reporting arrangements.

The table below demonstrates the activity of the NHS Board and Standing Committees in 2020-21:

Committee	**Chair**	**Quorate Meetings Held 2020/21**
NHS Dumfries and Galloway Board	Mr N Morris	13
Healthcare Governance Committee	Mrs P Halliday	4
Audit and Risk Committee	Dr L Douglas	4
Performance Committee	Mr N Morris	0
Staff Governance Committee	Ms L Bryce	5
Person Centred Health and Care Committee*	Mrs P Halliday	0
**this meeting was formally stepped down in October 2020*		

Public Board meetings were unable to go ahead as the pandemic set in, as a result there were 4 Board meetings in April and May where the public were unable to attend due to Covid-19 restrictions; the minutes were published on the website. From June the meeting papers and minutes were made public, but the public were still not allowed to attend and from November 2020, meetings were recorded and the recording, papers and minutes for each meeting were published on the website.

As noted under the summary of temporary governance arrangements Person Centred Health and Care Committee was stood down on 6th April 2020 and was disbanded on 7th October 2020. Performance Committee was stood down on 6th April 2020 and was not reinstated during 2020/21.

Operation of the Board

2020/21 has been dominated by the Covid-19 response, the Board has operated in an emergency response mode throughout the year and many areas of routine work have not been delivered upon as the pandemic placed unprecedented pressures on our clinical and support teams, some of which are described below.

It became very evident during 2020 that the Pandemic Plan in place did not support the response required for the emergence of a novel virus. The plan was revised and updated during 2020/21 but will need ongoing review and refinement based on the learning from the Covid-10 pandemic. In addition business continuity plans require to be reviewed to ensure that the revised working arrangements adopted during the pandemic are factored in.

Operational Management Arrangements during Covid-19 response

A key component of the operational response to the pandemic was a revised organisational command and control structure that operated throughout. This had three formal levels for direction and decision making as follows:

- Strategic (Gold) - to provide strategic direction and co-ordinate the sourcing of support for the NHS Board, Chaired by the Chief Executive or the on-call Executive Director, and accountable directly to the Board.
- Tactical (Silver) - to co-ordinate the allocation of resources in line with agreed priorities, and provide tactical planning to identify and address emerging issues. These included ensuring appropriate decisions were made with respect to advice, commissioning and prioritisation. Chaired by the Chief Officer and accountable directly to Strategic Pandemic Control.
- Operational (Bronze) – one for each operational area to provide advice to Tactical and enable implementation of decisions and directions relating to work streams. All Operational were led by a General Manager or Director and were accountable to Tactical.

These groups were supported by the Strategic and Tactical Local Resilience Partnerships which brings together individuals from across Dumfries and Galloway including NHS, IJB, Police, Local Authority and Fire and Rescue.

The command and control pandemic response arrangements were formally initiated during March 2020 and were only subsequently stepped down early May 2021.

Covid-19 recovery and remobilisation plans

The delivery of the National Waiting Times access targets has been extremely challenging given the suspension of elective work due to the Pandemic. Performance has significantly departed from the legislated Treatment Time Guarantee (TTG). This is consistent with all other Territorial Health Boards.

Additionally the work of the regional health improvement team which focuses on strategic health improvement work and addressing health inequalities was stood down during the year which requires to be addressed.

A remobilisation plan (RMP3) for 2021/22 has been approved and officially signed off by Scottish Government and outlines the recovery plan of planned care across all directorates and specialties. It also outlines our ongoing Public Health response to support the Covid-19 pandemic, remobilisation of Screening services and our Sustainability and Modernisation Programme. In addition specific focus is given to development of Mental Health and Psychology services given the longer term impact on Wellbeing that is evident as a result of the pandemic.

General operations of the Board

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.

NHS Dumfries and Galloway consult with all of its key stakeholders, this is continued focus for the year ahead, with further planned on community engagement and co-production. For 2020-21 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. The focus of this work during 2020-21 has been to support the Integration Joint Board in the development of the Strategic Commissioning Plan, with significant consultation and engagement work being undertaken through online and digital methods as face to face discussions have not been possible.

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. During the year Healthcare Governance Committee received confirmation that significant assurance was received from an internal audit on the complaints process, however Committee felt that they had not received significant assurance about learning from events and complaints.

We communicate with staff through various channels to ensure greater engagement and to encourage them to contribute to the 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. During the year we have enhanced our briefings with weekly (at some points daily) Covid-19 briefings providing essential Covid-19 related information to colleagues and partners, with any urgent information being issued separately. The Core Briefing continued to pick up any non-Covid and non-urgent or operational information. The #OnTheGround newsletter, issued on a monthly basis, celebrates staff and volunteer achievements, positive news and updates, and significant developments within the health and social care partnership.

The Board has a Whistleblowing policy in place for staff. The policy 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. During 2020-21 the Medical Director was the Boards designated whistleblowing lead and Ms M Caig, was the Non-Executive Champion. Operationally two senior managers are designated as Whistleblowing confidential contacts who are available to staff to raise appropriate concerns in a confidential manner. During 2020-21 the organisation received one Whistleblowing concern which is still being investigated.

The Board has processes in place to ensure that they are compliant with relevant legislation, regulations, guidance and policies as well as having policies in place for the development of internal policies. All policies, strategies or procedures are planned for review every three years as a minimum, or sooner if there is a specific legislative or service requirement or change in guidance, law or practice however there a number which are now significantly past their review dates. During the year an internal audit was carried out which indicated limited level of assurance in this area and it is recognised that significant improvements are required in our documentation and processes. The draft report has been issued with twenty one recommendations by internal audit. The recommendations will be progressed during 2021-22. This was an area which was de-prioritised during the pandemic as Corporate Services focused on the Covid-19 emergency response plan.

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) and this is reviewed annually.

Risk Management

NHS Dumfries and Galloway are subject to the requirements of the Scottish Public Finance Manual (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.

Risk Management is an essential feature of a modern healthcare organisation and although a risk free environment is impossible, much can be done to manage risk by having comprehensive policies and procedures that cover and permeate all areas of Board activities.

NHS Dumfries and Galloway have a risk management strategy (2021-2024) in place which forms a key part of the systems of internal control which ensures that staff, patients, visitors, the Boards reputation and finances are protected through the process of risk identification, assessment, control and elimination or reduction.

The aims of the strategy are:

- To develop a proactive approach to risk management
- To manage risk to an agreed and acceptable level and in particular the risk of harm to patients and staff
- To support the organisation in creating a culture of continuous improvement
- To ensure that there is a system of comprehensive organsational engagement in risk management activity
- To ensure the organisations policies and procedures support practitioners and managers to include risk management in decisions and improve and drive effective decision making
- To provide an educational framework that encourages the sharing of knowledge relating to both risk assessment and risk management to create a shared understanding.

The Audit and Risk Committee supports the Board in their responsibilities for risk, risk control and risk governance and associated assurance through constructive challenge. A quarterly report is provided at each meeting as well as an Annual Report.

The Risk Executive Group (REG) was established in January 2015 to oversee arrangements for risk management and ensure NHS Dumfries and Galloway has appropriate governance arrangements in place to maintain operational co-ordination of risk management, in accordance with the Board's Risk Management Strategy. REG membership comprises of the Chief Executive, the Executive Director for Nursing, Midwifery and Allied Health Professionals (NMAHP) and the Director of Finance, the Patient Safety Improvement Team Manager, the Risk Manager and the Board Corporate Manager. The Risk Executive Group currently meets monthly.

Risk Management responsibilities are delegated to the Risk Executive Group continues to provide the direction on risk for NHS Dumfries and Galloway. It reports on a quarterly basis to the Audit and Risk Committee to provide assurance on the effectiveness of the arrangements in place.

Risk arrangements at a tactical level have been affected by the pandemic, the previously introduced Tactical Health, Safety and Risk Group which reported directly to the Risk Executive Group has not been able to meet this year and its current terms of reference is now being reviewed.

Temporary arrangements were put in place from August 2020 to bring together individuals with key risk management roles to support the development of the risk management strategy and policy and this has now been replaced by the Risk Oversight Group to oversee the implementation.

In addition to the specific risk management training that has been undertaken during the year there are training programmes available to all staff which depending on the area of work includes training on risk assessments, health and safety, hazardous substances, general awareness of safety and display screen equipment risks, moving and handling and violence and aggression.

During 2019-2020 NHS Dumfries and Galloway's Internal Audit Team conducted its tri-annual review of NHS Dumfries & Galloway's Risk Management arrangements and reported a limited level of assurance on risk management. The audit identified a number of areas that required immediate action including a review and refresh of the organisational risk registers and the associated processes around ownership, review and management of risk.

The planned programme of work around Risk Management was paused in March 2020 as staff from the team were redeployed into other roles as a result of Covid-19 which had a significant impact on in year progress however a number of areas were progressed:

- The Risk Management Strategy and associated policy and procedures were refreshed; the Strategy was approved by the Board in April 2021.
- Significant changes have been made in year to the Risk Management Module (Datix) which contains the Risk Registers for the organisation. The Risk Register Module has been rebuilt and the new Risk Register form went live in early December 2020. Feedback from users

helped to further enhance functionality. The new risk assessment form which not reflects more clearly the operational, tactical and strategic risks and specialities was completed by the target date of March 31st 2021.

- Each Director and Corporate Team Leader engaged in a review of their risk register and over 500 risks (redundant or duplicate) had been removed from the organisation's Risk Registers. The process of adding the remaining risks is now ongoing and is due to be complete by August 2021. This was supported by the Risk Team to embed risk into all management processes.
- The Corporate Risk Register has been monitored and reviewed throughout the year and is overseen by Management Team, Board and Audit and Risk Committee. Each of the standing committees will continue to review their section of the Corporate Risk Register.
- The onset of the Pandemic in March, 2020 interrupted delivery of agreed Risk Management Training however the team have been able to provide various levels of training throughout the organisation during the year, reaching over 150 managers and staff. In addition a Board members workshop took place in April 2021 and focussed on the role of the Board in Risk Management.
- The formation of the Risk Oversight Group in February 2021 to oversee the implementation of NHS Dumfries and Galloway Risk Management Strategy and associated policies to ensure they are consistently and comprehensively adopted.
- All risk information and guidance is now hosted on the Boards intranet site to ensure easy access by all staff. This includes the Risk Management Strategy and Policy, Risk Management Guidance, Risk Management Tools and links to other associated internal and external web sites e.g. Health and Safety Executive, Occupational Health and Safety (SALUS), Scottish Patient Safety Programme (SPSP) and Datix.

Although a number of improvements have been made during the year Audit and Risk Committee are not yet fully assured that Risk Management is fully embedded with the Board and continue to seek assurance that the recommendations from the internal audit are addressed in a timely fashion. Some of the areas which continue to require further work are:

- Ensuring that Social Care staff and other Non NHS staff can report Adverse Events and Risks directly into Datix has not progressed this year. A workaround is in place to ensure that Risks and Adverse Events are recorded.
- Review of the Board's approved Risk Appetite Framework to ensure the appropriate tolerance levels for risk is managed and embedded within Risks Management organisation wide.
- Working with Directorates to further improve compliance with response times in respect of Internal & External Hazard and Safety Notices and Alert.
- Improved information reporting in the form of a data dashboard.
- Transfer of project risk registers on to the Datix system and regular reporting of these.
- Continuation of staff training.

Corporate Risks continue to be managed through the Risk Executive Group and reported to Audit and Risk Committee, with clinical risk reporting through to Healthcare Governance Committee, staff risks reporting through Staff Governance Committee and risks related to information governance, security and privacy reported through Information Assurance Committee. As part of the implementation of the Risk Management Strategy all corporate risks have been reviewed, this included the addition of four new risks during the year and the downgrading of one very high risk to high (sustainable workforce).

The Board is currently managing 20 corporate risks covering a variety of areas including staffing, health inequalities, financial risks, infrastructure and Covid-19. Currently 16 risks are graded as High and the remaining 4 risks as Medium. 8 risks are at the target level.

When identifying the risk level to the organisation both the likelihood and impact are scored and combined to produce an overall risk level rating of Low, Medium, High or Very High. Judgments about the acceptability or tolerability of a risk will depend on the context and the potential for the safe management of the risk, it also takes into consideration the present controls in place.

The score for likelihood is based on the likelihood of the event taking place at all or occurring or re-occurring and ranges from rare to its being almost certain. The score for impact is the potential scale and the impact of an event arising from the risk ranging from insignificant to a catastrophic event.

The table below shows the range of the current 20 risks across the risk matrix:

		IMPACT				
		Neglible	Minor	Moderate	Major	Extreme
LIKELIHOOD	Almost Certain			1		
	Likely			4	8	
	Possible			3	2	1
	Unlikely				1	
	Rare					

Key	Low	Medium	High	Very High

Further information on how the level of risk is assessed and what it means can be found on the Board website (https://www.nhsdg.co.uk/publications/) under health board policies section - risk register policy and procedure.

Assessment of corporate governance performance

Board Governance

During 2020/21 the Board established a Corporate Governance group to progress the work of the Once for Scotland Governance work and the Blueprint for governance. This work has been substantially slowed due to the pandemic but progress has been made in the latter part of the year in relation to review of Board and Committee minutes, Board assurance arrangements and development of a new template for Board reports. This group has a workplan which will be further progressed during 2021/22.

A number of workshops were facilitated during the year for Board members including sessions on the remobilisation plan, winter pressures, the Sturrock Report and Action plan and the strategic plan.

Leadership walk rounds were paused during the year and Healthcare Governance Committee have discussed a new patient safety walkround process, virtual due to Covid, and the concern that walkrounds had been stopped during the pandemic.

In addition to routine business the Board have received and discussed the revised command structure, surge plans, pandemic plan and remobilisation plans and used these to set annual tactical priorities.

Financial Governance

Financial Management has been intensive this year with the need to live forecast the likely impact of Covid-19 on budgets, adherence did remain strong during the year and a balanced financial position was achieved for 2020/21 as a result of cessation of elective activity and significant additional funding support from Scottish Government for Covid-19 expenditure. The Board still has a significant underlying financial deficit moving forward which the Board are aware of through regular reporting cycles, the Remobilisation plan outlines measures that the Board is considering to address projected future deficits.

Staff Governance

Staff Governance Committee have reported that a number of routine areas of work for staff have fallen behind as a result of the emergency response. In particular annual appraisals (exceptions to this are the Executive Cohort and Medics appraisals programmes which have been undertaken as normal during this period, due to their interconnectedness to pay); reporting; exit interviews and mandatory training have all been affected. This is a priority area for 2021/22.

During the year we have also seen a rise in grievances and employment tribunals relating to harassment and victimisation. Staff governance has been tasked with prioritising wellbeing for

2021/22 as one of their priorities. Significant investment in staff welfare projects has been prioritized with funding being provided by Endowments

The Board has identified a Spiritual Care Lead, however, due to Covid restrictions they have been unable to take up the post, this affects the Boards ability to comply with our legal responsibility regarding Spiritual Care. It is anticipated that once restrictions lift this situation will be rectified.

Clinical Governance

During the year two issues arose within our Central Services Sterilisation Department (CSSD). One involved a batch of items which didn't reach the required temperature that should have been re-processed and one where there was inadequate processes in place for recalling packs that had exceeded their sterilisation date. Whilst no patients came to harm and immediate actions were progressed once the issue was identified, this is an area of ongoing focus and review for the year ahead.

Information Governance

A welcomed additional assurance for the Audit and Risk Committee was also provided in the period by the external Network and Information Systems Regulations 2018 (NIS) Audit report which received a score of 71%. This was the highest score of any territorial Board across NHS Scotland. The recommendations from the audit have now also been added to the significant agenda within the IT Departments annual work plan.

The Board continues to experience challenges in data sharing between partner organisations where there is a conflict between confidentiality and appropriate access to patient and client data between ourselves and Dumfries and Galloway Council. Whilst there has been no risk of data breaches, difficulty in sharing information may have affected practioners' ability to carry out rapid assessments with the minimum of bureaucracy.

As highlighted in the Directors report six incidents were reported in year to the Information Commissioners Officer, no further action was taken by them and the actions required by the Board have been undertaken.

Internal Audit

Further assurance is taken from the work carried out by Internal Audit. Regular reports are provided to Audit and Risk Committee which gives independent assurances on audit work undertaken.

- The Chief Internal Auditor continues to report to myself and Audit and Risk Committee on the length of time taken to close off outstanding audit actions and as would be expected during the pandemic there has been a worsening of the position in year which Audit and Risk Committee also continue to raise with management as a concern.
- Audit and Risk Committee are responsible for ensuring progress is monitored on remedial action plans from previous Limited Assurance audits. The eEss limited assurance audit from last year has closed all outstanding actions.
- The risk management audit noted earlier continues to be reported to Audit and Risk Committee to ensure that it remains part of the agenda until all outstanding actions are closed. The Chief Internal Auditor has indicated that there has been two limited assurance audits and one moderate assurance audit in the last seven years which identifies one of the key weaknesses as being the lack of resources to drive this forward.
- The Boards Policy Framework audit completed during the current year and has been assessed as providing Limited Assurance as noted earlier. The progress against the twenty one recommendations will continue to be reported to Audit and Risk Committee until these are closed.

The Chief Internal Auditor has concluded that there were adequate and effective internal controls in place throughout the year and whilst highlighting a number of areas, can provide the opinion that I as Accountable Officer have implemented a governance framework in line with required guidance sufficient to discharge the responsibilities of this role.

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;
- The management of the Covid-19 pandemic through the command and control structure and through my leadership of Strategic Pandemic Control and the regular reports, updates and decisions made through this route;
- A review of key performance and risk indicators;
- The minutes and papers presented to the Board which demonstrate that the Board met regularly during 2020-21 to consider its plans, strategic direction, and response to the pandemic, 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 2020-21. All statements have been prepared by the lead Executive Director and Non Executive Chairperson and submitted to the their Committee for approval this process has been strengthened in year to align the statement with the Committee terms of reference, areas of good work as well as areas where improvements could be made were identified in all Committee statements;
- The work of the internal auditors, who provide 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.
- Comments made by the external auditors in their attendance at Audit and Risk Committee, their management letters and other reports;
- Management letters and other reports issued by the external auditors of the NHS Endowment Fund.
- 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. During 2020-21 two reports were received from Healthcare Improvement Scotland (HIS). One in relation to an unannounced visit to Lochmaben Hospital in which the Board received six areas of good practice and one improvement requirement which was acknowledged as a very positive result by the Cabinet Secretary. The second report was in relation to an announced visit at DGRI for Ionising Radiation (Medical Exposure) Regulations 2017 which resulted in two requirements and one recommendation. Action plans have been developed. A draft report on the DGRI facility by Health Facilities Scotland (HFS) has been received and is expected to be formally published in the second quarter of 2021/22.
- Reporting to NHS Board on the Financial Performance including the extent to which the Board is reliant on non-recurring sources to achieve financial targets.
- A review of Annual Service Audit Reports which are intended to provide assurance around the internal controls frameworks in place for a range of services provided on behalf of NHS Scotland. This includes Payments to Practitioners, IT Services and Finance Ledger Systems.
- Independent consideration of the governance statement and its disclosures by Internal Audit and Audit and Risk Committee.

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. It is recognised, however, that the pace of change necessitated by the pandemic created a far

more loosely controlled decision-making environment. Governance arrangements were adjusted to continue to provide assurance but, in recognition of our over-riding aim to minimise deaths from the pandemic, these could not fully replicate the controls present in more normal working circumstances.

Appendix 3

Annual Governance Statement 2020/21

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
- 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 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.

2.2 It enables the Council to monitor achievement of the Council Plan and also Community Planning Vision and Principles and the Outcomes which are set out in the region's Local Outcomes Improvement Plan and Locality Plan on food sharing.

Local Code of Corporate Governance

2.3 The Council's governance arrangements are reviewed and reported in accordance with statutory requirements and under a framework and guidance for Scotland called Delivering Good Governance in Local Government" (CIPFA, 2016). The Council's Local Code of Corporate Governance was agreed in 2019. It provides details of our key documents, policies and evidence which support our Governance Framework.

2.4 The Local Code adopts the seven core principles from the Framework:-

- Behaving with Integrity, demonstrating strong commitment to ethical values, and respecting the rule of law
- Ensuring openness and comprehensive stakeholder engagement
- Defining outcomes in terms of sustainable economic, social and environmental benefits
- Determining the interventions necessary to optimise the achievement of the intended outcomes
- Developing the entity's capacity. Including the capability of leadership and the individuals within it
- Managing risks and performance though robust internal control and strong public financial management
- Implementing good practices in transparency, reporting and audit to deliver effective accountability.

2.5 These principles and are broken down into sub-principles which facilitates a focussed evaluation of each element of our Local Code. A list of supporting evidence and documentation assists with determining the self- assessment and identifying improvement actions.

2.6 During 2020/21 we undertook an evaluation of our compliance with our Local Code of Corporate Governance. The identified improvement actions and evaluation agreed by Members inform this Governance Statement.

2.7 . Sound governance continued to operate during the period of disruption due to COVID 19 Pandemic. The suspension of the Scheme of Administration and Delegation to Committees, and operation of an Ad Hoc COVID19 Sub Committee was subject review on a monthly basis and was supported by Member seminars and opportunities for all Members to contribute their views to the Ad Hoc Sub Committee Members. The suspension of the Scheme of Delegation was for a very short period of three months

3. Improvements and changes to Governance arrangements during 2020/21

The progress we made in these six Improvement Actions arising from the 2019/20 AGS is set out below, along with other actions undertaken during 2020/21.

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 meeting of Dumfries and Galloway Council on 25 September 2020 agreed the addition of a fifth Priority and associated Commitments.. Our Council's Priorities are:
  - Build the local economy
  - Provide the best start in life for all our children
  - Protect our most vulnerable people
  - Be an inclusive council
  - Urgently respond to climate change and transition to a carbon neutral region
  - These Priorities and Commitments are used by Elected Members in considering strategic decisions, determining key performance measures, and allocation of resources.

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

- The Council Priorities and Commitments are regularly discussed in the context of feedback from the annual Budget Consultation, the Transformation Programme and consideration of the Business Plans every six months

- A Mid Term Review of the Council Plan was agreed by Full Council in September 2020 which comprised stakeholder engagement to informed a Members Seminar. *However, the engagement activity was suspended due to the second COVID Lockdown and…..*

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

The Council Plan sets out the range of policies and Plans that translate the high level Council Vision into specific issues:

- Regional Economic Strategy
- Children's Services Plan
- Health and Social Care Strategic Plan
- ICT and Digital Strategy
- Regional Tourism Strategy
- Major Festivals and Events Strategy
- Equalities Action Plan Volunteer Strategy
- Carbon Management Plan
- Customer Strategy

- Advocacy and Lobbying Strategy
- Anti Social Behaviour Strategy
- Financial Strategy Workforce Strategy
- Anti Poverty Strategy
- CLD Partners' Strategic Plan
- Community Engagement and Participants Strategy
- Active Travel Strategy
- Commercial development Plan
- Procurement Strategy
- Local Development Plan
- Education Authority Annual Plan
- Local Housing Strategy
- Regional Transport Strategy

- We also have Business Plans which set out how Services are contributing to the Council's Priorities and Commitments, how resources (staff and assets) are allocated to meet them and the risks associated with their Service and mitigations in place to address them.
- During 2020/21, our approach to Business Planning was updated to streamline the Business Plan and ensure that the COVID experience is reflected in our future plans
  Service Business Plans

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

- The quality of services for users is important for all our Services; and the Customer Strategy highlights the importance of customer feedback and that we amend our services to respond to that. There is a range of customer satisfaction performance measures in our Business Plans, particularly through annual surveys.
- Year on year quality performance information and comparator benchmarking data is embedded in Business Plan performance reports.
- 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

  Local Government Benchmarking Framework

- A range of other benchmarking and qualitative comparison is also carried out in individual Services, through professional organisations, national groups and dedicated quality and benchmarking organisations

- School Inspection Reports were circulated to Elected Members and summaries reported in Business Plan performance monitoring reports to Committees.
  Education Inspectorate Reports

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 and Protocols.
- The Council's Member-Officer Protocol serves to guide relationships between Members and Officers and lays out the arrangements for Member involvement in a range of activities including local issues. It incorporates a Media Protocol which embraces the Code of Recommended Practice on Local Authority publicity.
- Service Committees, Area Committees and the Audit, Risk and Scrutiny and Committee and other Sub Committees and forums have a clear remits that are set out in the Scheme of Administration and Delegation to Committees and the respective roles and responsibilities of the Integration Joint Board (IJB) and the Council have been defined and documented.
- The Scheme of Delegation to Offices and Statutory Appointments sets out the detailed delegations to the Chief Executive, Directors, the Chief. Social Work Officer, Heads of Service and statutory appointments.
- The concept of 'key decisions' is part of the Implementation Plan following the Review of Internal Financial Procedures and Procurement Standing Orders and agreed in February 2021; this is being developed by the Review of Standing Orders Sub Committee and due to be considered by Full Council in June 2021.

- The Scheme of Delegation to Officers and Statutory Appointments was updated in December 2020
  Updating of the Scheme of Delegation –December 2020

- Amendments to the Scheme of Establishment of the Integration Joint Board were approved by Full Council September 2020
  Scheme Report to Full Council in September 2020

- The Scheme of Establishment of Community Council Elections was updated during 2020 to provide for online meetings; and some minor improvements which had been identified by Community Councils
  Community Councils webpage on dumgal.gov.uk

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 also adopted the Standards Commission's Code of Conduct for Elected Members. 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.

A Review of Internal Financial Procedures and Procurement Standing Orders by the Finance, Procurement and Transformation Committee agreed recommendations relating to organisational culture and this work is being taken forward by a Member-Officer Working Group which was agreed by Full Council on 24 March 2020.
Review of Internal Financial Procedures and Procurement Standing Orders Implementation Plan

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(ROSO) 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, the Fairer Scotland Duty about inequality; and also takes into account health inequalities, social and economic sustainability.
- There remit and arrangements for Elected Member Champions, (Armed Forces, Environment, Events, Older People and Young Persons) were updated by Full Council in December 2020, following recommendations from the ROSO Sub Committee

- The Review of Standing Orders Sub-Committee met twice during 2020/21
Meetings of the Review of Standing Orders Sub Committee in 2020/21

- Elected Member Champions for Armed Forces, Environment, Events and Young People Annual Reports were submitted and approved

- Changes were agreed by Full Council in December 2020 to: the Sub Committee on Waste Strategy Implementation on the recommendation of the

ROSO Sub Committee; and the Bridge Sub Committee was stood down on the recommendation of the Education and Learning Committee

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

- The Council's Risk Management arrangements have been developed significantly during 2020/21 The Framework and template materials are available on the Council's intranet 'Connect' for easy access. 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.

- A new Sub Group of the CMT was established with representation from each Services. it has developed the strategic Risk Registers, submits them to CMT for monitoring on a quarterly basis, which in turn will make recommendations to the and the SLT to agree any changes.
- Each of the 11 Business Plans includes a Risk Register for the Service.

- A Risk Register was developed for the region in relation to the COVID Emergency and along with the UK Exiting the EU Risk Register, was reported to Full Council in June 2020

- The Council wide Business Risk Register was agreed by the Senior Leadership Team and reported to Audit, Risk and Scrutiny Committee in December 2020

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. The Council's financial control framework was reviewed in detail during 2020/21. • 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 and Scrutiny 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.
- Internal Audit will assist with fraud investigations where appropriate, but more serious allegations are referred at the first instance to Police Scotland
- 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

- To implement the Corporate Anti-Fraud and Corruption Policy, the Integrity Group membership was refreshed during 2020 with an Interim Chair in place from July 2020-February 2021. The Group met regularly during 2020/21 and reviewed the Anti-Fraud and Anti-Corruption Policy.

3.10 Ensuring Effective Management of Change and Transformation

- The Council supports the delivery of change, improvement, and transformation across the organisation by focusing on Council Priorities and deploying a range of recognised approaches to support the identification and delivery of opportunities to improve quality and transform services to meet these. These include using self-evaluation through Public Sector Improvement Framework; system and business process reviews, using lean approaches; service review programmes; implementing major business change projects; and benchmarking for improvement.
- The Council agrees a formal Budget Development process in place in June each year which includes stakeholder engagement and Impact Assessment.
- Our Council's Workforce Strategy sets out our workforce agenda within four key themes including; planning effectively for our Council's future needs (workforce and succession planning focus; Improve employee engagement; Enabling our employees to succeed, with the right skills, ability and knowledge to undertake new or revised roles; and building transferrable skills and support young people in finding employment.
- Our Management Development Programme is designed to upskill middle managers, make them more effective in delivering services and supporting our workforce
- Our Council Workforce Transition Board looks at workforce planning, voluntary severance and wider strategic workforce issues to ensure that we transform our Workforce to meet future needs.
- The Council's Transformation Programme reported regularly to the Finance, Procurement and Transformation Committee during 2020/21.
- The COVID19 Emergency which was declared in March 2020 demanded significant change in the arrangements for the conduct and management of Council business. This required an update to Standing Orders, agreed on 20 March 2020 and regular meetings of an Ad Hoc COVID-19 Sub Committee; as well as the establishment of a management structure to co-ordinate the work of different 'Cells' dealing with the Council's Response. The Sub Committee was stood down by Full Council in June 2020 and Committee meetings resumed after the summer recess.
  Ad Hoc COVID19 Sub Committee meetings
- A Scrutiny Review on the Long Term implications of Community Asset Transfers was completed by the Audit Risk and Scrutiny Committee during 2020/21 and the recommendations were agreed by Full Council in March 2021. This includes increased us of the Social Value assessment.
- An Investigation into the 4th Generation Trunk Road Maintenance Contract 2013-2018 was undertaken during 2020/21 and reported to Full Council in June 2020 and March 2021. Two Reviews were undertaken to deliver on its Findings – a Review of Internal Financial Procedures and Procurement Standing Orders which reported in February 2021 to Finance, Procurement

and Transformation Committee and Full Council and a Service Review of the Roads Service which reported to the Communities Committee and the Audit, Risk and Scrutiny Committee. the implementation of improvement actions from both of these Reviews are being monitored by the relevant Service Committee.

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 and 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).

  - The draft Annual Accounts were approved by the Full Council in June 2020

  - Annual Reports on Treasury Management and Procurement were approved by the FPT Committee in September 2020

  - The External Audit Plan for 2020/21was considered by Members in February 2021 and is now being implemented.

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 outturn of the 2019/20 Internal Audit Plan was reported to the Audit Risk and Scrutiny Committee on 22 September 2020; and the Annual Report for 2020/21 against the Strategic Plan for 2020-23 was also approved at that meeting.

- PSIAS external quality assessment of internal audit was agreed by Members in December 2019

Internal Audit Conformance with Professional Standards

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

- Our Council appoints a Monitoring Officer and two Deputies, who act when the Monitoring Officer is absent from the office or considers there is a conflict of interest. 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 the functions.
- The Chief Executive meets with the Monitoring Officer, and other statutory appointments monthly to consider and recommend action in connection with current governance issues and other matters of concern regarding probity.

- A new post of Head of Governance and Assurance was agreed by Full Council on 30 July 2020 and the post was filled from 1 January 2021.

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 and Statutory Appointments which was updated in December 2020

Scheme of Delegation and Responsibilities and Statutory Appointments to Officers

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 and Scrutiny Committee undertook a self evaluation against the Audit Scotland 'Audit Committee checklist' and considered the results along with an assessment of the Committee's work programme at its meeting on 16 February 2021
Audit Risk and Scrutiny Committee

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

- Annual Reports on key aspects of our business are presented to Members for approval, including Procurement, Treasury Management, Internal Audits, Scrutiny Reviews.
- The Review of Internal Financial Procedures and Procurement Standing Orders by the Finance, Procurement and Transformation Committee agreed a number of recommendations relating to internal financial procedures at its meeting in February 2021 which are now being implemented
- Review of Internal Financial Procedures and Procurement Standing Orders Implementation Plan
- The Audit, Risk and Scrutiny Committee undertook a review of the Service and Area Committee reporting and Scrutiny arrangements and at its meeting on 16 February 2020 agreed that the arrangements were effective.

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 Complaints Handling software was updated in October 2020 to provide for better tracking and handling of complaints. We publish 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.

- The Communities Committee agreed a new Complaints Handling Procedure for Council's services, consistent with the new national Model Procedure, at its meeting on 9 February 2021

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

- Members have open access to a range of training and Continuing Professional Development (CPD) events on an individual basis and are supported in identifying their training and Continuing Professional Development. Complementary to the formal programme, is a series of briefing events and seminars on new legislation and policies and there are Members Seminars to inform the Service Business Plans.

- Our Council promotes the Improvement Service programme for Elected Members. Members have the opportunity to self and peer group assess themselves against the skills profile of their role using 360◦ appraisals

- 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 Service's Objectives. Completion rates are reported in the Service Business Plans.

- Responsibility for Elected Member training and development was transferred to Democratic Services in July 2020

- A Scrutiny Review of Support to Elected Members has been undertaken during 2020/21 and this has included a survey of Members about the training and development needs; engagement with the Improvement Service; and benchmarking with other Scottish councils. It is due for reporting to Full Council in June 2021.

- An annual Performance Development Review was undertaken for all Members of the Corporate Management Team during 2020/21.

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

- Community empowerment continues to be a strength for our Council and the implementation of the Community Participation and Engagement Strategy and Framework, Ward Events, Participatory Budgeting exercises and Community Conversations (discussions with communities about the services in their area) have all progressed well. The Review of Standing Orders Sub Committee reviewed the use of Ward Events in December 2020 and agreed no changes to the Protocol.

- Engagement work with the Health and Social Care Partnership and NHS, D&G has been embedded with the established Participation and Engagement Network (a voluntary citizens panel); the creation of a Climate Change Citizens Panel is developing well; and the relationship with the new Community Councils has been strengthened through the COVID Emergency and the updating of the Scheme of Establishment to allow for virtual meetings.

- Consultation Mandates were agreed for the development of key strategies and plans including RRR, the new Poverty and Inequalities Strategy, the new Gaelic Action Plan, the new CLD Partnership Plan, and the refresh of the Disposal and Acquisition Policy.

- The Mainstreaming Report for 2019-21 and Equalities Outcomes for 2021-2024 were agreed by Full Council on 24 March 2021.

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

- The Local Outcomes Improvement Plan Annual Report was agreed by the Community Planning Partnership Board in November 2020.
  CPPB meetings

  Our Full Council and the Social Work Committee has considered reports about the relationship with the Integration Joint Board, including the Annual Report

and the Clinical and Care Governance report, required as part of the Scheme for Integration.

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

- The Council is a key partner in the region's Community Planning Partnership Board and Executive Group and their work programmes include scrutiny of Annual Reports on the work of thematic partnerships and working groups; and regular updates on the ten plans and strategies that contribute to the Local Outcomes Improvement Plan. All of this work is promoted on the Community Planning webpages and features in communications including social media.

- 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.
  CP Operating Protocol

- The Community Planning Partnership Improvement Plan for 2020/21 and Risk Register 2020/21were agreed by the CPP Board in November 2020

- A new COVID Recovery Group and a Poverty and Inequality Partnership were agreed by the CPP Board in September 2020 and March 2021 respectively.
  CPPB meetings

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 Senior Leadership Team (Chief Executive, three Directors, the Chief Social Work Officer and Chief Officer RRRR) which meets weekly ;and the Corporate Management Team (all Heads of Service) which also meets weekly, with additional senior officers participating on a fortnightly basis.

4.2 The agendas of these management groupings during 2020/21 covered all aspects of the Council's corporate arrangements particularly finance, OD and HR; property; business planning; Health and Safety; participation and engagement; key strategic projects and programmes. The CMT had a programme of reports about key corporate issues including e.g. Impact Assessment, Community Participation and Engagement. A review is scheduled at the conclusion of the programme.

4.3 Elected Members are central to the Council's governance arrangements and there is a healthy culture of questions and challenge, evidenced by some modernisation in adopting remote access.

4.4 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 2020/21 was based on the assessment of risks and consultation with the Corporate Management Team.

Internal Audit communicates its findings through reports to operational management. These reports are also reviewed by the Audit, Risk and Scrutiny Committee 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.

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

5. Improvement Plan for 2021/22

5.1 There are two outstanding actions from the 2019/20 Improvement Plan

- Mid point Review and updating of the Corporate Plan to include the Climate Change Priority – by end 2020 – Director Economy and Resources
- Review of Member Appointments to Outside Bodies – by May 2021 – Director Communities

5.2 Actions for improvement are contained within the Implementation Plan from the Internal Financial Controls and Procurement Standing Orders Review.

6. Conclusion

On the basis of the review of governance arrangements for 2020/21, it is confirmed that the Council:

- has continued to focus on its Council Plan and appropriately added a Priority on Climate Change
- has introduced an improvement to its business planning arrangements with new Service Business Plan templates that reflect the impact of the COVID19 Pandemic
- has worked with its partners to deliver shared outcomes for its citizens and customers, notwithstanding a challenging budget environment
- 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
- has managed its risks effectively
- has responded appropriately when performance has not been adequate

- has made good progress in the Best Value Assurance Report Improvement Plan;

- and it has ensured Elected Members and Officers 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 2021.