CORPORATE GOVERNANCE ATTESTATION STATEMENT
MID NORTH COAST LOCAL HEALTH DISTRICT

The following corporate governance attestation statement was endorsed by a resolution of the Mid North Coast Local Health District Board at its meeting on 9 August 2023.

The Board is responsible for the corporate governance practices of the Mid North Coast Local Health District. This statement sets out the main corporate governance practices in operation within the District for the 2022/23 financial year.

A signed copy of this statement is provided to the Ministry of Health by 31 August 2023.

Signed:

Peter Tresedor

Chair Date

Paul Connor

A/Chief Executive Date 27/07/2023

STANDARD 1: ESTABLISH ROBUST GOVERNANCE AND OVERSIGHT FRAMEWORKS

Role and function of the Board and Chief Executive

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

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

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

Board Meetings

For the 2022-23 financial year the Board consisted of a Chair and 12 members appointed by the Minister for Health. The Board met 13 times during this period.

Authority and role of senior management

All financial and administrative authorities that have been delegated by a formal resolution of the Board and are formally documented within a Delegations Manual for the District.

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

Regulatory responsibilities and compliance

The Board is responsible for and has mechanisms in place to ensure that relevant legislation and regulations are adhered to within all facilities and units of the District, including statutory reporting requirements.

The Board also has a mechanism in place to gain reasonable assurance that the District complies with the requirements of all relevant government policies and NSW Health policy directives and policy and procedure manuals as issued by the Ministry of Health.

STANDARD 2: ENSURING CLINICAL RESPONSIBILITIES ARE CLEARLY ALLOCATED AND UNDERSTOOD

The Board has in place frameworks and systems for measuring and routinely reporting on Clinical Governance and the safety and quality of care provided to the communities the District serves. These systems and activities reflect the principles, performance and reporting guidelines as detailed in NSW Health Policy Directive '*Patient Safety and Clinical Quality Program'* (PD2005_608).

The District has:

- Clear lines of accountability for clinical care which are regularly communicated to clinical staff and to staff who provide direct support to them. The authority of facility/network general managers is also clearly understood.
- Effective forums in place to facilitate the involvement of clinicians and other health staff in decision making at all levels of the District.
- A systematic process for the identification and management of clinical incidents and minimisation of risks to the District.
- An effective complaint management system for the District and complaint information is used to improve patient care.
- A Medical and Dental Appointments Advisory Committee to review the appointment or proposed appointment of all visiting practitioners and specialists. The Credentials Subcommittee provides advice to the Medical and Dental Appointment Advisory Committee on all matters concerning the clinical privileges of visiting practitioners or staff specialists.
- An Aboriginal Health Advisory Committee with clear lines of accountability for clinical and other health services delivered to Aboriginal people.
- Adopted the *Decision-Making Framework for NSW Health Aboriginal Health Practitioners Undertaking Clinical Activities* to ensure that Aboriginal Health Practitioners are trained, competent, ready and supported to undertake clinical activities.
- Achieved appropriate accreditation of healthcare facilities and their services.
- Licensing and registration requirements which are checked and maintained.
- A Medical Staff Executive Council, at least two Medical Staff Councils and a Mental Health Medical Staff Council (or an alternative mechanism established in accordance with the Model By-Laws
- A Hospital Clinical Council for each public hospital in the entity (where appropriate that Council may be a Joint Hospital Clinical Council covering more than one hospital).
- A Local Health District Clinical Council

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

Health services are required to be accredited to the National Safety and Quality Health Service (NSQHS) Standards under the Australian Health Service Safety and Quality Accreditation Scheme (the AHSSQA Scheme).

The District intends to submit an attestation statement confirming compliance with the NSQHS Standards for the 2022/23 financial year to their accrediting agency by 30 September 2023. The District submitted an attestation statement to the accrediting agency for the 2022/23 financial year.

STANDARD 3: SETTING THE STRATEGIC DIRECTION FOR THE ENTITY AND ITS SERVICES

The Board has in place strategic plans for the effective planning and delivery of its services to the communities and individuals served by the District. This process includes setting a strategic direction in a 3- to 5-year strategic plan for both the District and the services it provides within the overarching goals of the 2022/23 NSW Health Strategic Priorities.

District-wide planning processes and documentation is also in place, covering:

- Detailed plans linked to the Strategic Plan for the following:
  - Asset management
    - Asset management plan (AMP) (See qualification page 12)
    - Strategic asset management plan (SAMP) (See qualification page 12)
    - Information management and technology (See qualification page 12-13)
    - Research and teaching (See qualification page 13)
  - Workforce management (See qualification page 13)
- Local Health Care Services Plan
- Corporate Governance Plan (See qualification page 13)
- Aboriginal Health Action Plan

STANDARD 4: MONITORING FINANCIAL AND SERVICE DELIVERY PERFORMANCE

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

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

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

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

To this end, Board and Chief Executive certify that:

- The financial reports submitted to the Finance & Performance Committee and the Ministry of Health represent a true and fair view, in all material respects, of the District's financial condition and the operational results are in accordance with the relevant accounting standards
- The recurrent budget allocations in the Ministry of Health's financial year advice reconcile to those allocations distributed to units and cost centres.
- Overall financial performance is monitored and reported to the Finance and Performance Committee of the District.
- Information reported in the Ministry of Health monthly reports reconciles to and is consistent with reports to the Finance and Performance Committee.
- All relevant financial controls are in place.
- Write-offs of debtors have been approved by duly authorised delegated officers.

Service and Performance

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

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

The Finance and Performance Committee

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

The Finance and Performance Committee receives monthly reports that include:

- Financial performance of each major cost centre
- Subsidy availability
- The position of Restricted Financial Asset and Trust Funds
- Activity performance against indicators and targets in the performance agreement for the District

- Advice on the achievement of strategic priorities identified in the performance agreement for the District
- Year to date and end of year projections on capital works and private sector initiatives.

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

During the 2022-23 financial year, the Finance and Performance Committee was chaired by Luke Hartsuyker and comprised of:

- Neil Porter/Michael Coulter – Non-Executive Board Member
- Stewart Dowrick – Chief Executive
- Paul Connor – Director Finance & Performance
- Kathleen Ryan – Director Clinical Governance & IT
- Vicki Simpson/Carolyn Heise – Director Nursing & Midwifery
- Melanie Mearns – A/Director Internal Audit & Finance
- Kate Vandoros – Associate Director Finance

The Chief Executive and Director of Finance attended all meetings of the Finance and Performance Committee except where on approved leave.

STANDARD 5: MAINTAINING HIGH STANDARDS OF PROFESSIONAL AND ETHICAL CONDUCT

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

The Code of Conduct is distributed to, and signed by, all new staff and is included on the agenda of all staff induction programs. The Board has systems and processes in place to ensure the Code is periodically reinforced for all existing staff. Ethics education is also part of the District's learning and development strategy.

The District has implemented models of good practice that provide culturally safe work environments and health services through a continuous quality improvement model.

There are systems and processes in place and staff are aware of their obligations to protect vulnerable patients and clients – for example, children and those with a mental illness.

The District has implemented the NSW Health Services Aboriginal Cultural Engagement Self-Assessment Tool (ACESAT) and has action plans in place to support the District in meeting the six Aboriginal specific actions of the National Safety & Quality Health Service Standards. (Not fully implemented. Refer to qualification on page 13-14).

The Chief Executive, as the Principal Officer, has reported all instances of corruption to the Independent Commission Against Corruption where there was a reasonable suspicion that corrupt conduct had, or may have, occurred, and provided a copy of those reports to the Ministry of Health.

During the 2022-23 financial year, the Chief Executive reported *4* cases to the Independent Commission Against Corruption.

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

During the 2022-23 financial year, the District reported 0 of public interest disclosures.

The Board attests that the District has a fraud and corruption prevention program in place.

STANDARD 6: INVOLVING STAKEHOLDERS IN DECISIONS THAT AFFECT THEM

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

During the development of its policies, programs and strategies, the Entity considered the potential impacts on the health of Aboriginal people and, where appropriate, engaged with Aboriginal stakeholders to identify both positive and negative impacts and to address or mitigate any negative impacts for Aboriginal people.

The Mid North Coast Aboriginal Health Accord 2019-2023 (The Accord) has brought together five key health agencies in a shared leadership model and renewed cooperation to improve the health of Aboriginal communities on the Mid North Coast. The partners to the Accord are:

- Durri Aboriginal Corporation Medical Service (Kempsey)
- Galambila Aboriginal Health Service Incorporated (Coffs Harbour)
- Mid North Coast Local Health District
- Healthy North Coast (North Coast Primary Health Network (North Coast Primary Health Network)
- Werin Aboriginal Medical Centre (Port Macquarie)

This Accord aligns with Aboriginal Health Plans at State and National levels and represents the next step at the regional and local level to improve Aboriginal health outcomes. It seeks to bring about necessary improvements in health service delivery for the Aboriginal community of the Mid North Coast through collective action. It rests on the notion that Aboriginal health is everybody's business, and that well planned and targeted activity from many stakeholders working together has greater potential for success than each agency acting alone.

The vision of the partners under the Accord is optimal health and wellbeing for Aboriginal people on the mid north coast. There are five (5) overarching **principles** guiding the partnership under the Accord as follows:

- **Partnership, Not Competition:** We are not competitors in the provision of health care for Aboriginal people on the Mid North Coast, we are Partners.
- **Leadership for Health:** Strong leadership in healthcare is required on the Mid North Coast to bring about necessary Aboriginal health reform.
- **Innovation and Creativity:** Creative exploration of new solutions to old problems will be the spirit needed for success in improving Aboriginal health outcomes.
- **Quality and Excellence:** The pursuit of constantly improving health services and the achievement of best possible health practice is central to the Accord.
- **Equity in Healthcare:** The Aboriginal community requires improved access to quality healthcare if current poor health outcomes are to be reversed.

Mid North Coast Aboriginal Health Authority under the Accord

The New Accord 2019-2023 was signed in 2020. The Mid North Coast Aboriginal Authority (the Authority), comprising the CEOs of each of the Accord Partners, is a dedicated working committee giving effect to the Accord vision. The Authority meets a minimum of three times per year.

In addition to the above, the following Clinical Networks operational partnership committees are in place:

Galambila Aboriginal Health Service and Coffs Clinical Network Strategic Working Group. The Working Group provides guidance and engagement on the delivery of health services to ensure the needs of the local Aboriginal communities; are culturally safe and appropriate with smooth transitions in care between service provides. Priority areas for the Group are to identify service gaps in the Aboriginal Communities and work in partnership to improve on the Aboriginal health service deliverables and health outcomes.

Hastings Macleay Clinical Networks has two committees, the Kempsey District Hospital Aboriginal Advisory and the Port Macquarie Base & Wauchope District Memorial Hospital Aboriginal l Advisory Committee and they act as a conduit between the hospital and the Aboriginal community bring the Aboriginal voice to the table to support community engagement, consultation into the planning, and delivery of culturally responsive health services for the Aboriginal community. Due to Covid-19 face to face meetings were limited.

MNCLHD's liaison with other agencies, development of local partnerships and consumer and community engagement

During 2002, a review of consumer consultative processes was undertaken and MNCLHD Local Health Advisory Council (LHAC) was established in 2023 to function as an advisory group of the Governing Board, aligned with recommendations and principles of NSW Parliamentary Inquiry into Rural and Regional Healthcare published May 2022, associated consultation process led by NSW Regional Health Division completed December 2022 and MNCLHD Strategic Plan 2022-2023.

LHAC fulfils an organisational-wide role in providing advice to the Governing Board to support effective coordination and promotion of purposeful engagement with our community. Delivery of this objective will ensure the consumer voice is integral in shaping the health service and is central to decision making at all levels of the organisation.

LHAC terms of reference reflect continued consumer engagement focus with membership reflective of a strong consumer representative cohort of at least 50% and key staff with decision making authority.

MNCLHD engages consumer and community representatives across a variety of activities including:

- Committees (steering, advisory, reference, working groups)
- Consultations, forums, focus groups and workshops
- Section and recruitment panels
- Special projects (such as new capital developments)

Examples from Integrated Mental Health and Alcohol and Other Drugs (IMHAOD) include but are not limited to:

- Joint Regional Planning Group – initiative between the LHD and Health North Coast (PHN).
- Ongoing MNCLHD Mental Health Consumer Advisory Group (initiate, resource, support).
- Continued growth of the IMHAOD Peer workforce including the first time a specialist AOD Consumer worker.

- IMHAOD Service Coordinator – Partnerships and Planning has a core role of partnership with external organisations.
- Suicide prevention collaborative in each network brings together a number of external partners providing suicide prevention activities.
- Continued strong partnership with Aboriginal Medical Services.
- AOD Services partnership with NSW User and AIDS Association (NUAA).
- Disaster Recovery Team provides community engagement services in partnerships with Department of Primary Industry, State Emergency Services and other key agencies.

Information on the key policies, plans and initiatives of the District and information on how to participate in their development are available to staff and to the public at https://int.mnclhd.health.nsw.gov.au/ and https://mnclhd.health.nsw.gov.au/

STANDARD 7: ESTABLISHING SOUND AUDIT AND RISK MANAGEMENT PRACTICES

Role of the Board in relation to audit and risk management

The Board is responsible for supervising and monitoring risk management by the District and its facilities and units, including the system of internal control. The Board receives and considers all reports of the External and Internal Auditors for the District, and through the Audit and Risk Management Committee ensures that audit recommendations and recommendations from related external review bodies are implemented.

The District has a current Risk Management Plan that identifies how risks are managed, recorded, monitored, and addressed. It includes processes to escalate and report on risk to the Chief Executive, Audit and Risk Committee and Board. (Not fully implemented. Refer to qualification page [14])

The Plan covers all known risk areas including:

- Leadership and management
- Clinical care and patient safety
- Health of population
- Finance (including fraud prevention)
- Communication and information
- Workforce
- Legal
- Work health and safety
- Environmental
- Security
- Facilities and assets
- Emergency management
- Community expectations

Audit and Risk Management Committee

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

- to assess and enhance the District's corporate governance, including its systems of internal control, ethical conduct and probity, risk management, management information and internal audit
- to ensure that appropriate procedures and controls are in place to provide reliability in the District's financial reporting, safeguarding of assets, and compliance with the District's responsibilities, regulatory requirements, policies, and procedures
- to oversee and enhance the quality and effectiveness of the District's internal audit function, providing a structured reporting line for the Internal Auditor and facilitating the maintenance of their independence
- through the internal audit function, to assist the Board to deliver the District's outputs efficiently, effectively, and economically, so as to obtain best value for money and to optimise organisational performance in terms of quality, quantity and timeliness; and
- to maintain a strong and candid relationship with external auditors, facilitating to the extent practicable, an integrated internal/external audit process that optimises benefits to the District.

The District completed and submitted an Internal Audit and Risk Management Attestation Statement for the 12-month period ending 30 June 2023 to the Ministry without exception.

The Audit and Risk Management Committee comprises 4 members of which 4 are independent and appointed from the NSW Government's Prequalification Scheme for Audit and Risk Committee Independent Chairs and Members.

QUALIFICATIONS TO THE GOVERNANCE ATTESTATION STATEMENT

Item: Standard 3: Setting the strategic direction for the Organisation and its services: The Board has in place strategic plans for the effective planning and delivery of its services to the communities and individuals served by the District: Asset management plan (AMP) and Strategic asset management plan (SAMP).

Qualification

- The District had not finalised the Asset Management Plan & Strategic Asset Management Plan within the 2022/23 financial year.

Progress:

- The Districts Asset Management Plan (AMP) and Strategic Asset Management Plan (SAMP) are delayed due to issues in the template which was producing abnormal costings. Update in costings for the Districts Capital Investment Proposal is underway.

Remedial Action:

- The SAMP and AMP Reports is now complete and has been endorsed by the Finance and Performance Sub-Board Committee Meeting on 25 July 2023.

Item: Standard 3: Setting the strategic direction for the Organisation and its services: The Board has in place strategic plans for the effective planning and delivery of its services to the communities and individuals served by the District: Information management and technology.

Qualification:

- The District did not have a Local Health District (LHD) Digital Plan for the 2022/23 financial year.

Progress:

- The District has recently recruited a Director – Digital Health. The Director – Digital Health will work with relevant stakeholders to develop a LHD Digital Plan.

Remedial Action:

- The District will develop and implement a detailed Digital Plan by the end of the 2023/24 financial year.

Item: Standard 3: Setting the strategic direction for the Organisation and its services: District-wide planning processes and documentation is also in place, covering: Detailed plans linked to the Strategic Plan for the following: Research and Training.

Qualification:

- The District did not have detailed plan for Research and Knowledge during the 2022/23 financial year.

Progress:

- The District's *Research and Knowledge Strategy 2023-2028* is in final stages of consultation.

Remedial Action:

- MNCLHD Annual Research report is in preparation and will be published in October 2023. The District's Research and Knowledge Strategy 2023-2028 is in final stages of consultation

Item: Standard 3: Setting the strategic direction for the Organisation and its services: The Board has in place strategic plans for the effective planning and delivery of its services to the communities and individuals served by the District: Workforce Management.

Qualification:

- The People and Culture (PAC) Directorate are implementing the NSW health Workforce Plan but do not have a specific MNCLHD Workforce Plan at this time.

Progress:

- Draft Nursing Workforce Plan has been developed.

Remedial Action:

- A Strategic Workforce Plan will be developed in 23/24.

Item: Standard 3: Setting the strategic direction for the Organisation and its services: The Board has in place strategic plans for the effective planning and delivery of its services to the communities and individuals served by the District: Corporate Governance Plan.

Qualification:

- Finalisation of the Corporate Governance plan was not able to be completed in 2022-23 but development has commenced. The MNCLHD has implemented a Corporate Governance Framework. A Corporate Governance Plan is being developed but was not finalised before the end of the financial year.

Progress:

- The Corporate Governance Plan is under development with the Manager Governance and Executive Services.

Remedial Action:

- The Corporate Governance Plan is due for completion by 31 March 2024.

Item: Standard 5: Maintaining High Standards of Professional and Ethical Conduct: The District has implemented the NSW Health Services Aboriginal Cultural Engagement Self-Assessment Tool (ACESAT) and has action plans in place to support the District in meeting the six Aboriginal specific actions of the National Safety & Quality Health Service Standards.

Qualification:

- Not all Directorates had completed an Aboriginal Cultural Engagement Self-Assessment for the 2022-23 financial year.

Progress:

- The District has endorsed the NSW Health Services ACESAT, and the ACESAT has been uploaded to the Quality Audit Reporting System (QARS) by the Clinical Excellence Commission. MNCLHD Directorates/Networks are completing Self Assessments and Action Plans directly in QARS, supported by ACESAT in-services conducted by the Aboriginal Health Strategy Unit (AHSU). In addition, the AHSU also provide quarterly reports on the progress of the ACESAT to the Close the Gap Board Subcommittee and a User Guide has been published.

Remedial Action:

- Internal Audit is undertaking an internal audit to identify improvement opportunities in relation to the District's use of the Aboriginal Cultural Engagement Self-Assessment Tool.

Item: Standard 7: Establishing Sound Audit and Risk Management Practices: The District has a current Risk Management Plan that identifies how risks are managed, recorded, monitored, and addressed.

Qualification:

- NSW Health Policy Directive PD2022_023 *Enterprise-wide Risk Management Policy* published 1 July 2022 was updated to remove the mandatory requirement for the health organisations to have a Risk Management Plan.

Progress:

- The District's Enterprise-wide Risk Management Procedure was reviewed in 2022-23, in alignment with section 4 of PD2022_023: *"All NSW Health organisations must have an enterprise-wide risk management procedure in place that outlines how the organisation will identify, assess, manage, and monitor risks. It must include processes for escalating risks and for providing risk reports to the senior executive team, the Chief Executive, the Audit and Risk Committee and Board".* The District is currently developing a Risk Management Framework and Risk Management Plan.

Remedial Action:

- The Risk Management Framework and Risk Management Plan are due to be completed by 30 September 2023.

Signed:

Paul Connor

A/Chief Executive Date 27/07/2023

Melanie Mearns

Chief Audit Executive Date 27/07/2023