Highland Health Board

Annual report on the 2011/12 audit

AUDIT SCOTLAND

Prepared for Highland Health Board and the Auditor General for Scotland
July 2012

Audit Scotland is a statutory body set up in April 2000 under the Public Finance and Accountability (Scotland) Act 2000. It provides services to the Auditor General for Scotland and the Accounts Commission. Together they ensure that the Scottish Government and public sector bodies in Scotland are held to account for the proper, efficient and effective use of public funds

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Key messages

2011/12

The Scottish public sector faces significant challenges in balancing budgets while also delivering on its commitments. In 2011/12 we assessed the key strategic and financial risks being faced by Highland Health Board. We audited the financial statements and we also reviewed the use of resources and aspects of performance management and governance. This report sets out our key findings.

We have given an unqualified audit report on the financial statements of Highland Health Board for 2011/12. We also concluded that in all material respects, the expenditure and income shown in the financial statements were incurred or applied in accordance with applicable enactments and relevant guidance issued by Scottish Ministers.

The Board achieved all of its financial targets in 2011/12 and returned a saving against its total Revenue Resource Limit of £0.084 million as at 31 March 2012. In 2011/12 the Board achieved its planned savings of £18.9 million, although over £10.9 million of these savings were achieved on a non-recurrent basis and will require to be achieved recurrently in 2012/13. The Board's financial planning arrangements include regular monitoring, reporting and updating of information to allow potential risks to be addressed promptly.

In 2011/12, the Board had sound governance arrangements in place which included a number of standing committees overseeing key aspects of governance. These included an Audit Committee, Staff Governance Committee and Clinical Governance Committee. The Board also had an effective internal audit function and anti-fraud arrangements.

In May 2011, the Board and the Highland Council signed a Partnership agreement for integration of health and social care services. Single lead agency arrangements for Adult Community Care Services (NHS Highland) and for Children's Services (the Highland Council) came into effect on 1 April 2012. Following the establishment of the new arrangements, both organisations are working on the next phase of redesign which will see services evolving in an integrated way. A forward plan detailing the scope of the work being carried forward has been agreed. The Board has also agreed to continue the current programme board approach and is in the process of recruiting a programme manager to ensure the forward plan is delivered.

The Board has a well developed framework in place for monitoring and reporting performance. In 2011/12 the Board has met all of the HEAT targets that were due in 2011-12 and, in a number of areas, performance continues to improve. However some performance standards were not fully achieved and in those cases the Board has established actions to improve performance.

The Board has arrangements in place to consider national performance reports issued by Audit Scotland, with local action plans in place to address any recommendations for improvement.

Outlook

The position going forward is becoming even more challenging than previous years with limited increases in funding, increasing cost pressures in respect of prescribing growth and utility costs, and challenging savings targets. To achieve continuing financial balance the Board will be required to deliver £23.8 million of recurring cost savings in 2012/13 through initiatives which target quality, safety and efficiency through the redesign of services. This represent a major challenge for the Board and expenditure during the year will require to be closely monitored to identify and address any emerging budget pressures or projected overspends at an early stage.

The significant financial challenges that the Board will face in 2012/13 and beyond will require it to further prioritise its use of resources. This will make maintaining or improving on the performance targets set by the Scottish Government even more challenging.

Introduction

1. This report is the summary of our findings arising from the 2011/12 audit of Highland Health Board. The purpose of the annual audit report is to set out concisely the scope, nature and extent of the audit, and to summarise the auditor's opinions (i.e. on the financial statements) and conclusions and any significant issues arising. The report is divided into sections which reflect the extent of our public sector audit model.

2. A number of reports have been issued in the course of the year in which we make recommendations for improvements (Appendix A). We do not repeat all of the findings in this report, but instead we focus on the financial statements and any significant findings from our wider review of Highland Health Board.

3. Appendix B is an action plan setting out the high level risks we have identified from the audit. Officers have considered the issues and agreed to take the specific steps in the column headed "planned management action". We do not expect all risks to be eliminated or even minimised. What we expect is that Highland Health Board understands its risks and has arrangements in place to manage these risks. The Board and Accountable Officer should ensure that they are satisfied with the proposed management action and have a mechanism in place to assess progress.

4. This report is addressed to the Board and the Auditor General for Scotland and should form a key part of discussions with the Audit Committee, either prior to or as soon as possible after the formal completion of the audit of the financial statements. Reports should be made available to stakeholders and the public, as audit is an essential element of accountability and the process of public reporting.

5. This report will be published on our website after consideration by the Board. The information in this report may be used for the Auditor General's annual overview of the NHS in Scotland's financial performance later this year. The overview report is published and presented to the Public Audit Committee of the Scottish Parliament.

6. The management of the Board is responsible for preparing financial statements that show a true and fair view and for implementing appropriate internal control systems. Weaknesses or risks identified by auditors are only those which have come to our attention during our normal audit work, and may not be all that exist. Communication by auditors of matters arising from the audit of the financial statements or of risks or weaknesses does not absolve management from its responsibility to address the issues raised and to maintain an adequate system of control.

Financial statements

7. Audited bodies' financial statements are an essential part of accounting for their stewardship of the resources made available to them and their performance in the use of those resources.

8. Auditors are required to audit financial statements in accordance with the timescales set by Audit Scotland, which may be shorter than statutory requirements, and give an opinion on:
   - whether they give a true and fair view of the financial position of audited bodies and their expenditure and income
   - whether they have been properly prepared in accordance with relevant legislation, the applicable accounting framework and other reporting requirements
   - the regularity of the expenditure and income.

9. Auditors review and report on, as appropriate, other information published with the financial statements, including the director's report, governance statement and the remuneration report. This section summarises the results of our audit of the financial statements.

Audit opinion

10. We have given an unqualified opinion in that the financial statements of Highland Health Board for 2011/12 give a true and fair view of the state of the body's affairs and of its net operating cost for the year.

11. Highland Health Board is required to follow the 2011/12 Government Financial Reporting Manual (the FReM) and we confirm that financial statements have been properly prepared in accordance with the FReM.

12. We have also reviewed the Board's governance statement and concluded that it complies with Scottish Government guidance.

Regularity

13. The Public Finance and Accountability (Scotland) Act 2000 imposes a responsibility on auditors that requires us to certify that, in all material respects, the expenditure and income shown in the accounts were incurred or applied in accordance with applicable enactments and guidance issued by Scottish Ministers. We have been able to address the requirements of the regularity assertion through a range of procedures, including written assurances from the Accountable Officer as to her view on adherence to enactments and guidance. No significant issues were identified for disclosure.

Accounting issues

14. Our audit plan included a timetable for providing an audit opinion on the financial statements on 29 June. At the request of the Board, this timetable was brought forward to mid-June. As agreed, the unaudited accounts were provided to us on 8 May 2012 supported by a

comprehensive working papers package. The good standard of the supporting papers and the timely responses from Highland Health Board staff allowed us to conclude our audit within the revised timetable and provide our proposed opinion to the Audit Committee on 18 June 2012.

15. As required by auditing standards we reported to the Audit Committee on 18 June 2012 the main issues arising from our audit of the financial statements. The main points are detailed in the following paragraphs.

Non current assets

16. The Board's balance sheet included property plant and equipment and intangible assets with a net book value of £312 million at 1 April 2011. Details of the individual categories of assets are included at notes 10 and 11 to the accounts. The Board's asset register records detail of assets held, and is the primary evidence source to support the detail within notes 10 and 11. As part of our audit work, we were able to reconcile the net value of these assets included in the fixed asset register to the net book value at 1 April 2011 of £312 million included in the accounts. However, we were unable to agree the opening gross asset cost of £400 million and opening gross depreciation of £87 million per the draft accounts to the gross values included in the asset register.

17. Following audit review, the gross asset cost and accumulated depreciation included in the accounts were adjusted downwards by £44 million. In addition a £4 million downwards adjustment was required to both the in-year revaluation figure and the depreciation charge. These adjustments had no net impact on the balance sheet.

18. We were advised by officers that the difference between the asset register and the accounts had resulted from the Board's treatment of revaluation adjustments in previous years. During 2012-13 officers intend to review the revaluation reserve to provide additional assurance that the balances held in the reserve are accurately recorded.

Risk Area 1

Capital Resource Limit (CRL)

19. The draft accounts disclosed an underspend against the Board's CRL of £5,000. Audit testing found an error in the Board's calculation and the underspend was revised to £304,000. Officers subsequently identified a number of capital payments relating to the 2011-12 financial year totalling £228,000 which had not been included in the draft accounts. A further adjustment to the accounts has been made, and the revised underspend against CRL was £76,000. The Board is not permitted to carry forward this underspend.

Equal Pay Claims

20. The National Health Service in Scotland has received in excess of 10,000 claims for equal pay and 304 of these relate to Highland Health Board. These have been referred for the attention of the NHS Scotland Central Legal Office (CLO) to co-ordinate the legal response to this issue.

21. Developments over the past year have slowed the progress of claims and led to a reduction of claims going forward. The CLO has stated that claims still do not provide sufficient detail about the comparator jobs to allow an estimate to be made of the likelihood of the success of the claims or any financial impact they may have. The CLO and NHS Scotland Equal Pay Unit are monitoring the progress of claims as well as developments relating to NHS equal pay claims elsewhere that may further inform the position.

22. Discussions have been held between Audit Scotland, their partner firms, the Scottish Government and the CLO to ascertain the appropriate accounting treatment of equal pay claims in 2011/12. Given the CLO's advice that although some liability is probable, it is not possible to estimate the impact of the claims, it has been agreed that disclosure as an unquantified contingent liability remains appropriate for the 2011/12 financial statements of affected NHS boards.

23. We continue to strongly encourage Highland Health Board management, working with Scottish Government Health and Social Care Directorate, the CLO and other NHS boards to form a view of the potential liabilities as soon as possible taking into account the progress of cases in Scotland and England.

24. As with other boards, Highland Health Board has not been able to quantify the extent of its liability for Equal Pay claims. There is a risk that these liabilities could have an impact on the Board's financial position.

Risk Area 2

Agenda for Change

25. As at 31 March 2012, £1.246 million was accrued in respect of the remaining costs associated with the agenda for change process. This figure relates to expected arrears payments for staff originally placed on transitional points of the Agenda for Change scales. The estimation is based on NHS Highland's assumptions and refers to a range of staff posts and grades.

Risk Area 3

Surplus Sites Agreement

26. In 2000 NHS Highland agreed a property transaction connected to the New Craigs PFI. As part of this transaction there was an arrangement (known as surplus sites agreement) concerning land at Craig Dunain Hospital which required the contractor to pay the Board the higher of the guaranteed base price or the base price plus a fifty percent share in any development surpluses arising from the development of the fourteen individual sites.

27. As at 31 March 2012, £6.226 million of accrued income was recognised in NHS Highland's financial statements in respect of anticipated income from the remaining undeveloped sites. This amount was based on professional advice from Montagu Evans on the likely income that would be achieved for each of the sites, and the Board has also provided assurances that this amount, in their judgement, represents a prudent estimate of anticipated income. Due to the

current economic climate and continuing uncertainty surrounding the property market it is important that the level of realisible income is kept under review.

Risk Area 4

Prior year adjustments - donated assets and transfer of prisoner healthcare

28. The 2011/12 FReM required boards to change the accounting treatment for donated assets which led to the removal of the donated asset reserve from their accounts. This requirement was a change in accounting policy which was reflected in the financial statements of Highland Health Board with appropriate amendments made to prior year statements.

29. In addition, responsibility for the healthcare of prisoners transferred from the Scottish Prison Service to health boards on 1 November 2011. The transfer was a machinery of government change, which the FReM requires to be accounted for using merger accounting and entailed prior year comparatives being restated and adjusted to achieve uniformity of accounting policies. The appropriate adjustments to prior year comparatives have been reflected in the financial statements.

Heritage assets

30. A heritage asset is a tangible asset with historical, artistic, scientific, technological, geophysical or environmental qualities that is held and maintained principally for its contribution to knowledge and culture. From 2011/12 boards were required to separately disclose any heritage assets. The Board conducted a review of non-current assets which identified that no such assets are held by the Board.

Outlook

Endowments

31. As a result of an agreed derogation from the FReM NHS Scotland boards were not required to consolidate endowment funds within their 2011/12 financial statements, in terms of IAS 27, Consolidated and Separate Financial Statements. The Treasury and Scottish Government have delayed the consolidation of NHS Endowment Funds until financial year 2013/14.

Financial position

32. Audited bodies are responsible for conducting their affairs and for putting in place proper arrangements to ensure that their financial position is soundly based.

33. Auditors consider whether audited bodies have established adequate arrangements and examine:

- financial performance in the period under audit
- compliance with any statutory financial requirements and financial targets
- ability to meet known or contingent, statutory and other financial obligations
- responses to developments which may have an impact on the financial position
- financial plans for future periods.

34. These are key areas in the current economic circumstances. This section summarises the financial position and outlook for the organisation.

The Board's financial position as at 31 March 2012

35. Highland Health Board is required to work within the resource limits and cash requirement set by the Scottish Government Health and Social Care Directorates (SGHSCD). In 2011/12, the SGHSCD required NHS boards to differentiate between core and non-core expenditure for both revenue and capital.

36. The Board achieved all its financial targets in 2011/12 as outlined in Table 1 below:

Table 1: 2011/12 Financial Targets Performance £'000s

Financial Target	Target	Actual	Variance
Revenue Resource			
Core	542,546	542,463	83
Non Core	25,237	25,236	1
Capital resource			
Core	12,738	12,662	76
Non Core	227	227	-
Cash position			
Cash requirement	608,000	607,224	776

37. The Board has achieved a surplus of £0.084 million. The Board had budgeted to breakeven against its Revenue Resource Limit in 2011/12. Historically, boards have relied upon a measure of non-recurring funding to achieve financial targets. However, due to the one-off

nature of this type of funding, the tighter financial settlement compared to the past and reduced flexibility within expenditure budgets, there is less scope for reliance on non-recurring income to achieve financial balance as NHS boards seek to rationalise their cost base.

38. Also, in 2011/12 the Board recorded an underlying deficit of £8.827 million, which represents the shortfall of recurring funding and savings over recurring expenditure commitments, carried forward into 2012/13. The delivery of sufficient recurring savings in 2012/13 and future years will be a significant challenge for the Board.

Capital Resource Limit

39. The Board underspent by £76,000 against its total Capital Resource Limit (CRL) in 2011/12 with total capital expenditure of £12.889 million and total CRL of £12.965 million. The total capital allocation was made up of £12.738 million of core capital allocations and £0.227 million of non-core capital allocations. The non-core allocation of £0.227 million relates to capital expenditure on PFI schemes and was fully utilised.

Workforce reduction

40. Staff costs account for a significant proportion of board expenditure and in response to the Board's total savings target of £23.8 million in 2012/13, the workforce contribution to savings is expected to be in the region of £14 million. Through service redesign (including changing the skill mix) and increased workforce productivity combined with reduced costs, the workforce contribution to savings will continue to be progressed against the on-going delivery of the key workforce plans.

41. The new integrated Adult Health and Social Care Services and Children's Services (see paragraph 69 below) which began in April 2012 will require the continued development of workforce plans, including the potential creation of integrated roles, to continue supporting transition throughout 2012/13.

Financial planning to support priority setting and cost reductions

Financial sustainability and the 2012/13 budget

42. Uplifts in financial settlements have been reducing in recent years. The general uplift for 2011/12 was 1.1% (after adjusting for the loss of prescription income and the introduction of the Change Fund) compared to an uplift of 3.15% two years ago. This pattern has continued into 2012/13, with the Board's baseline revenue funding uplift being confirmed as 1% (or £4.8 million). The Board has received a total 'notional' funding uplift of 2.5% which includes the transfer of prisoner healthcare funding and Change Fund. Given the current economic conditions and the impact of national spending priorities, there is a continued risk that funding uplifts will be lower in future years. These pressures will have a significant impact on long term financial planning and the control of pay and non-pay costs.

43. The Board continues to face significant cost pressures relating to the rate of growth in prescribing costs and the anticipated increases in workforce costs and supplies during

2012/13. All additional expenditure will require to be met from the Board's existing resource. Any significant fluctuations in these costs will present a major challenge to Highland Health Board achieving financial balance for the coming year.

44. In 2011/12 the Board's cost savings plan was pivotal to it achieving financial balance. The plan set a cost savings target of £18.9 million, with £8 million being achieved on a recurrent basis and the remaining £10.9 million being achieved on a non-recurrent basis.

45. The Board plans to break even in 2012/13 and its ability to achieve financial balance is again largely dependent on it successfully developing and implementing a comprehensive cost savings plan. For 2012/13, £23.8 million of recurring cost savings comprising £10.9 million savings target for the year, £8.9 million non-recurring savings carried forward from the previous year and £4.4 million relating to Adult Social Care are required. The financial plan also reflects resource transfers relating to the Integration agendas around Adult Social Care and Children's Services, with approximately £90 million of resources transferring into NHS Highland and approximately £8.5 million transferring out. The actual financial impact of the integration agenda is another area that may be subject to fluctuation going forward.

46. Cost savings are to be achieved through a number of means, including service redesign, strict vacancy management, more efficient procurement practices and a continued focus on primary care prescribing costs. Efficiencies at the Board are inextricably linked to the quality agenda. The Board's mantra is: *quality without efficiency – unsustainable; efficiency without quality – unthinkable*. This is prominently displayed in various buildings and in Board reports. Efficiency and quality improvements are clearly set out in the NHS Highland Strategic Framework and progress towards delivery of the framework can be seen through the LEAN reviews and the work done by GE Healthcare Performance Solutions aimed at improving operational, clinical, and management processes. It is clear from discussions with officers and review of Board papers that the quality agenda has a high profile. The Board has invested considerable time and effort in identifying more efficient ways of working but has yet to reap the full benefits of this work and more needs to be done to release cash efficiencies on a recurring basis

47. The delivery of the cost savings plan in 2012/13 will be more challenging than it has been in recent years. The level of flexibility within expenditure budgets is considerably reduced by the release of cost savings in previous years. Failure to achieve planned cost savings will impact on the Board's ability to achieve a break even position.

48. The Board's Local Delivery Plan (LDP) for 2012/13 aligns its strategic priorities with its financial plans, workforce plans and asset plans. The Board's financial planning arrangements include regular monitoring, reporting and updating of information to allow potential risks to be addressed properly. It is therefore important that the Board continues to closely monitor costs in order to take any required remedial action through supplementary cost saving schemes.

Risk Area 5

Outlook

Significant financial risks beyond 2012/13

49. The Board's 2012/13 financial plan indicates that the Board will be required to achieve cash savings of up to £15.7 million per annum in future years in order to achieve financial balance. The majority of the cost savings in each year are expected to be generated from recurring sources. These levels of savings will be extremely challenging as the majority of readily achievable savings initiatives will have already been identified in recent years.

50. Furthermore the financial plan assumes that future total indicative funding uplifts will be in the range of 2.5% to 2.8% for the period 2013/14 to 2016/17. This combined with growing cost pressures, will make the delivery of cost savings even more important.

Risk Area 5

Pension costs

51. The financial statements include a net pension costs liability of £370 million for the NHS Superannuation Scheme based on an actuarial valuation carried out for the year to 31 March 2004. A more recent actuarial valuation was carried out at 31 March 2008, however the publication of this valuation was placed on hold by HM Treasury pending the outcome of public sector pension reforms. Given periodic actuarial valuations are key to determining the adequacy of employer and employee contributions to the Scheme, publication of the latest actuarial valuation will bring clarity as to the adequacy of current contributions to meet the future commitments of the Scheme.

Governance and accountability

52. The three fundamental principles of corporate governance – openness, integrity and accountability – apply to all audited bodies, whether their members are elected or appointed, or whether they comprise groups of people or an individual accountable officer.

53. Through its chief executive or accountable officer, each body is responsible for establishing arrangements for ensuring the proper conduct of its affairs including the legality of activities and transactions, and for monitoring the adequacy and effectiveness of these arrangements. Audited bodies usually involve those charged with governance (including audit committees or similar groups) in monitoring these arrangements.

54. Consistent with the wider scope of public audit, auditors have a responsibility to review and report on audited bodies' corporate governance arrangements as they relate to:
    - corporate governance and systems of internal control
    - the prevention and detection of fraud and irregularity
    - standards of conduct and arrangements for the prevention and detection of corruption

55. In this part of the report we comment on key areas of governance.

Corporate governance

Processes and committees

56. The corporate governance framework within Highland Health Board is centred on the Board which is supported by a number of standing committees that are accountable to it including:
    - Audit Committee
    -
    - Clinical Governance Committee
    - Staff Governance Committee
    - Improvement Committee

57. The following paragraphs provide a brief comment on the main standing committees:

58. The Audit Committee assists the Board in ensuring that activities, including Patients Private Funds and Endowment Funds, are managed within the law and regulations governing the NHS. It also ensures that there is an effective system of internal control which is maintained to give reasonable assurance that assets are safeguarded, waste or inefficiency avoided and reliable financial information is produced and that value for money is continuously sought. The Committee is assisted by both internal and external audit and senior officials are invited, as appropriate, to respond to auditors' reports.

59. The Clinical Governance Committee assists the Board in delivering its statutory responsibility for the provision of quality healthcare. In particular, the Committee seeks to give assurance to the Board that appropriate systems are in place, which ensure that clinical governance and clinical risk management arrangements are working effectively to safeguard and improve the quality of clinical care.

60. The purpose of the Staff Governance Committee is to provide assurance to the Board that Highland Health Board meets its obligations in relation to staff governance under the National Health Service Reform (Scotland) Act 2004 and the Staff Governance Standard. In particular, the Committee seeks to ensure that staff governance mechanisms are in place that establish responsibility for performance against the Staff Governance Standard and ensure progress towards its achievement.

61. The Improvement Committee undertakes detailed, high level scrutiny of the Board's performance against the Local Delivery Plan and local targets and focuses upon those areas of performance where improvement is required to meet targets and improve outcomes. The Committee also receives the Balanced Scorecard, which measures the Board's performance against HEAT targets, on a two monthly basis to allow areas of suboptimal performance to be scrutinized in detail by the Committee. Following each meeting of the Improvement Committee a Board Assurance Report is completed and submitted to the subsequent Highland Health Board meeting. This report identifies the issues and risks associated with the delivery of HEAT targets and highlights the actions being taken by operational units to improve performance.

Patient safety and clinical governance

62. Patient safety is at the heart of clinical governance and risk management and a number of national arrangements and initiatives are in place to assist boards in this area. NHS Healthcare Improvement Scotland (NHS HIS) has lead responsibility for reviewing boards' performance in relation to patient safety, and for working with boards to improve patient safety. The remit of the Healthcare Environment Inspectorate (HEI - part of HIS) is to reduce the risk of healthcare associated infections (HAIs) in acute hospitals through assessment, inspection and reporting of boards' performance against HAI standards.

63. During 2011-12 there were two announced inspections, to MacKinnon Memorial Hospital (Broadford, Isle of Skye) and Belford Hospital (Fort William), both in July 2011. The reports of these visits were published towards the end of August 2011. For Belford Hospital the review resulted in two requirements and three recommendations while MacKinnon Memorial Hospital received two requirements and five recommendations. Both reports were followed up by an unannounced inspection in May 2012 which were reported in June 2012. The overall conclusion of the reports was that Highland Health Board is making good progress against the NHS QIS standards to protect patients, staff and visitors from the risks of acquiring an HAI. However, some areas for further improvement have been identified, particularly in relation to patient isolation and involvement of all staff groups. The Board has developed an action plan in response to these reports and it is expected that all actions will be completed by August 2012. The Infection Control Manger will continue to perform monthly HEI–type inspections

and report to the Board on a bi-monthly basis to give the Board assurance that these high standards of practice are being maintained.

64. The Board has an Infection Control Team which contributes to meeting the associated HEAT targets to reduce HAIs so that by March 2013: staphylococcus aureus bacteraemia (SAB) cases are 0.26 or less per 1,000 acute occupied bed days; and the rate of Clostridium difficile infections (CDI) in patients 65 and over is 0.39 cases or less per total occupied bed days. At June 2012, the Board reported that both these standards are currently being achieved. A Significant Event Review on the Clostridium difficile outbreak in Raigmore Hospital in January 2012 was also completed.

Partnership Working

65. Partnership working in the NHS covers a number of areas, including partnerships with staff groups, local authorities, the voluntary sector, private healthcare providers and regional planning with other NHS boards. The Board has established Community Health Partnerships (CHPs) to provide care and public health services in a local setting to meet the needs of the local population. It is also the intention that CHPs will contribute to one of the key principles set out in the Scottish Government's Better Health, Better Care publication which emphasises the need for 'ensuring better, local and faster access to health care'.

66. As a result of the Planning for Integration programme (see paragraphs 68 to 73) it was decided that, with effect from 1 April 2012, the Board's CHP structure would be reorganised. The 3 CHPs (North, Mid and South-East) whose geographical locations are co-terminous with The Highland Council's geographical area have been merged into one to form the Highland Health and Social Care Partnership (HH&SCP - known as Northern CHP). Argyll & Bute CHP, which for most clinical services is oriented towards Greater Glasgow & Clyde Health Board, remains the second CHP in the Highland Health Board area.

67. Each CHP is held to account through its own governance committee, with a new Highland Health and Social Care Partnership (HH&SCP) Governance Committee being established from 1 April 2012. The Board continues to monitor and adapt the new arrangements to ensure targets are prioritised and measurable.

Planning for integration

68. Partnership working is very much a developing area at a national level. In December 2011 the Cabinet Secretary for Health and Wellbeing announced the Scottish Government's plans to integrate adult health and social care across local government and the NHS. The main proposals are as follows:

- Community Health Partnerships will be replaced by Health and Social Care Partnerships (HSCPs) The partnership will be the joint responsibility of the NHS and local authorities, and will work with the third and independent sectors
- HSCPs will be accountable to Ministers, leaders of local authorities and the public for delivering new nationally agreed outcomes. These will initially focus on improving older people's care.

- NHS Boards and local authorities will be required to produce integrated budgets for older people's services.
- The role of clinicians and social care professionals in the planning of services for older people will be strengthened.

69. In May 2011, Highland Health Board and the Highland Council formally agreed to commit to planning for integration of health and social care services by putting into place single lead agency arrangements for Adult Community Care Services (NHS Highland) and for Children's Services (the Highland Council). Both bodies have joint responsibility for specifying the outcomes to be achieved for service users and for the totality of resources allocated to each of the two service areas. A formal implementation programme plan was also approved by the Board and Council in May 2011.

70. The Partnership agreement between the Board and the Highland Council was signed by representatives of both authorities on 21 March 2012 ahead of the commencement of the new arrangements on the 1st of April. The Partnership agreement details the governance arrangements put in place as well as the model for financial disbursements, resource allocation and reporting arrangements.

71. The focus initially was in meeting the 1 April 2012 target date for establishment of the single lead agency arrangements. However, it was recognised from the outset that this was only the first stage and in fact after the transfer date there would be a period of redesign which would see services evolving in an integrated way. The on-going process would involve all stakeholders and focus on developing new ways of service delivery that reflected a commissioning approach and focussed on the agreed outcomes.

72. At the Board meeting of 5 June 2012 a forward plan was presented detailing the scope of the work being carried forward. Major areas of work are still to be carried out in relation to:

- property - interim arrangements are in place and work is on-going to determine the future accommodation need for both adult and children's services
- finance - both organisations recognise the need for clarity around financial treatments and plans are being developed to address financial areas including accounting, billing and income and invoice processes
- human resources - work continues to resolve staffing issues on a more permanent basis, including payroll, occupational health, health & safety and personnel
- information management and technology - this is the most complex aspect of the on-going work given the differing approaches adopted by both organisations and a longer term project plan has been developed and a project manager identified.

73. The Board has also agreed the proposal to extend the current programme board approach and the appointment of a programme manager to ensure the forward plan is delivered. Recruitment of a programme manager is currently under way.

Transfer of Prisoner Healthcare

74. From 1 November 2011 responsibility for the provision of healthcare services to prisoners transferred from the Scottish Prison Service to individual health boards. Within the Highland area, the Board became responsible for providing healthcare at HMP Inverness which account for 1.7% of the Scottish prison population and has an associated cost of £0.538 million in 2011/12.

Internal control

75. While auditors concentrate on significant systems and key controls in support of the opinion on the financial statements, their wider responsibilities require them to consider the financial systems and controls of audited bodies as a whole. However, the extent of this work should also be informed by their assessment of risk and the activities of internal audit.

76. Key controls within systems should operate effectively and efficiently to accurately record financial transactions and prevent and detect fraud or error. This supports a robust internal control environment and the effective production of financial statements. In their annual report for 2011/12 Scott-Moncrieff, the Board's internal auditors, provided their opinion that, based on the internal audit work undertaken during the year, there were no significant concerns that required specific mention in the annual governance statement.

77. As part of our 2011-12 audit work we reviewed the high level controls in a number of Highland Health Board systems that impact on the financial statements. This audit work covered a number of areas including cash income and banking, trade payables, trade receivables, family health services, payroll and general ledger. Our overall conclusion was that Highland Health Board had adequate systems of internal control in place in 2011/12. We identified some areas where controls could be strengthened and agreed an action plan of improvements with management. This will be followed-up at a future date to confirm that improvements have been made.

Internal Audit

78. A key element of our work on internal controls is the extent of reliance that we can place on the work of internal audit in terms of International Standard on Auditing 610 (Considering the Work of Internal Audit). We carried out a review of internal audit in January 2012 and concluded that the internal audit service operates in accordance with Government Internal Audit Standards and has sound documentation standards and reporting procedures in place. We placed reliance on aspects of internal audit work in a number of areas, specifically, capital accounting, cash and bank, general ledger, trade payables and receivables specifically related to the high level Financial Systems Healthcheck report. This not only avoided duplication of effort but also enabled us to focus on other significant risks.

Governance Statement

79. The governance statement, provided by the Board's Accountable Officer, reflects the main findings from both internal and external audit work, and highlights the process by which the

accountable officer obtains assurances over the adequacy and effectiveness of the system of internal control. This is a new format of disclosure for 2011-12 as specified by the SGHSCD. The new format includes the requirement for an overt assurance that arrangements have been made to ensure best value. Overall it was concluded by the Board that no significant control weaknesses or issues have arisen, that no significant failures have arisen in the expected standards for good governance, risk management and control, and that appropriate arrangements for Best Value are in place. Our audit has confirmed that we concur with this assessment.

ICT review of data networking infrastructure

80. As part of our 2011/2012 audit we reviewed the management arrangements for the data networking infrastructure within NHS Highland. The review included network security, policies and procedures, and network configuration and connectivity.

81. We found that overall the data networking infrastructure is well managed and provides good connectivity, within some bandwidth limitations resulting from the geographical spread of the Board's sites. After integration of the A&B CHP into NHS Highland the physical data networks were integrated. This integration allowed for the provisioning of services across the NHS Highland area, for example, a Board-wide intranet. A project is currently underway to provide seamless connectivity across NHS Highland to support closer working relationships between staff of the Argyle & Bute CHP and the Northern CHP. This will allow staff to log in and use their systems anywhere in the Board area where there is a network connection.

82. A small team within the eHealth department is responsible for all network related activities which includes maintaining relationships with the suppliers of the data networking services. Due to this being a small team, the impact of staff leaving or long term illness has a major impact that needs to be managed carefully. During 2012, a member of staff left and this led to some delays in implementing network management software. However, the delays did not impact on service delivery and the post has now been filled.

83. Under the current tight capital resource limits, the planned renewal schedule of eHealth equipment is prioritised against the replacement schedules for other departments, for example, medical devices and estates. The Board continues to face challenges with the allocation of resource to ensure that all service delivery assets are replaced within the optimum timeframe. Extending the lifecycles of equipment can lead to difficulties and may reveal unforeseen side effects, for example, memory upgrades may be required to allow new software utilities to run. Emergency funding is available where failure beyond economic repair occurs, however the more equipment that remains in use past its intended lifecycle the greater the risk that demands on the emergency funds will exceed availability. In addition, the process to acquire emergency funding can be lengthy which in turn may affect the reliability of connections and service delivery.

Risk area 6

84. The Board's risk management arrangements include maintaining a strategic risk register and individual risk registers for each CHP and operational unit. It has a risk management policy in

place and a Risk Management Steering Group which has an overseeing role. At present, the eHealth risk register details 3 risk areas, however these were not identified through a formal risk assessment process. Evidence for the use of risk management techniques in eHealth is limited to project risks which are managed by the department until the end of the project and then transfer to the relevant service. Further benefits could be gained from implementing a more consistent approach to risk management in eHealth in order to identify any technological risks that could impact the Board as a whole.

Risk area 7

Use of Government Procurement Cards and Other Credit Cards

85. Across the public sector government procurement cards have been used to reduce the costs relating to the purchase of small items and some internet based purchases where a credit card is the most effective way of making payment. A recent significant fraud in another public body, which in part resulted from misuse of the government procurement card, highlighted that bodies need to ensure that their processes for the use of these cards are fit for purpose.

86. As part of our audit we carried out a high level review of the use of such cards within the Board and the controls applied to them. During 2011/12 the Board did not use any government procurement cards, however it did use a Royal Bank of Scotland credit card, along with a Premier Inn card for hotel accommodation only. The total spend on these cards in the year was £0.438 million.

87. We concluded that the controls within the credit card system were generally operating effectively. However, the average monthly expenditure of £40,000 on the Royal Bank of Scotland corporate credit card was around a fifth of the agreed credit limit. A higher than necessary credit limit may increase the risk of fraudulent activities going undetected and following discussions with officers the limit was reduced by a third.

NHS Boards Annual Reports

88. NHS boards are required to publish an annual report. The principal purpose of the annual report is to account to the community the board serves and to other stakeholders for key aspects of its performance during the year, and to give an account of its stewardship. The presentation, structure, design, format and distribution of local NHS annual reports is a matter for individual NHS boards.

89. In 2010-11 Highland Health Board moved away from producing a glossy annual report and opted to issue a newsletter to every home in the area. Whilst this clearly addressed the requirement to make the annual report accessible to as many local people as possible, the newsletter did not include the minimum set of summary financial information necessary to meet the Scottish Government requirements.

Risk area 8

Prevention and detection of fraud and irregularities

90. Audited bodies are responsible for establishing arrangements to prevent and detect fraud and other irregularity. Auditors review and report on these arrangements.

91. Highland Health Board has a range of measures in place to prevent and detect fraud, including a Fraud Policy which was approved in 2010. A Code of Conduct for staff and a fraud policy are in place. The Board has also entered into a formal partnership agreement with NHSScotland Counter Fraud Services (CFS) and a Fraud Liaison Officer is in place to ensure reports are circulated to appropriate managers and to the Audit Committee.

92. The Board's internal audit function has a formal programme of work, which provides assurance on the operation of the control systems which are designed to prevent fraud. Additionally, the Board has agreed a formal protocol covering a programme of Payment Verification checks with the Practitioner Services Division of NHS National Services Scotland.

93. At the start of the audit year the Board did not have a whistleblowing policy. We were advised that this would be put in place following the update to the Implementing & Reviewing Whistleblowing Arrangements in NHSScotland PIN Policy. The revised PIN was issued in December 2011 and we await the Board's response to this. We have concluded that in all other respects, the Board's arrangements are appropriate.

NFI in Scotland

94. Highland Health Board participates in the National Fraud Initiative (NFI). This is a counter-fraud exercise that uses computerised techniques to compare information about individuals held by different public bodies, and on different financial systems, to identify circumstances (matches) that might suggest the existence of fraud or error. Where matches are identified, public bodies are required to investigate these matches and, if fraud or error has taken place, to stop payments and attempt to recover the amounts involved.

95. The most recent data matching exercise collected data from participants in October 2010 and the national findings were published by Audit Scotland in May 2012. Specific arrangements are monitored at a local level as part of the ongoing audit. Based on the 2010/11 exercise, the outgoing auditors concluded that the Board is proactive in preventing and detecting fraud including participation in the NFI.

96. Participants should now be preparing for the 2012/13 exercise where data will be requested by October 2012. The national report published in May 2012 includes a self-appraisal checklist that all participants were recommended to use prior to NFI 2012/13.

Standards of conduct and arrangements for the prevention and detection of corruption

97. Audited bodies are responsible for ensuring that their affairs are managed in accordance with proper standards of conduct and have proper arrangements in place for implementing and monitoring compliance with standards and codes of conduct, standing orders and financial

instructions. Auditors consider whether bodies have adequate arrangements in place. We have concluded that the arrangements in Highland Health Board are satisfactory and we are not aware of any specific issues that we need to identify in this report.

Outlook

NHS Waiting Times

98. The Auditor General has asked Audit Scotland to examine the use of patient unavailability codes in the management of NHS waiting times. This follows the recent critical review into NHS Lothian's reported misuse of patient unavailability codes and recognises the importance of this for patients and the public and the need for independent assurance.

99. Audit Scotland will look at how these codes were being used by health boards in Scotland during the past year and will prepare a report on its findings which the Auditor General will present to Parliament after its summer 2012 recess. In addition, boards' internal auditors have been requested by the SGHSCD to carry out a review of waiting times as part of their 2012/13 internal audit plans. The results of this work are to be reported by 17 December 2012.

Best Value, use of resources and performance

100. Accountable officers have a specific responsibility to ensure that arrangements have been made to secure best value.

101. The Auditor General may require that auditors consider whether accountable officers have put in place appropriate arrangements to satisfy their corresponding duty of best value. Where no requirements are specified for auditors in a period they may, in conjunction with their audited bodies, agree to undertake local work in this area.

102. As part of their statutory responsibilities, the Auditor General and the Accounts Commission may procure, through Audit Scotland, examinations of the use of resources by audited bodies and publish reports or guidance. Auditors may be requested from time to time to participate in:

- a performance audit which may result in the publication of a national report
- an examination of the implications of a particular topic or performance audit for an audited body at local level
- a review of a body's response to national recommendations.

103. Auditors may also consider the use of resources in services or functions, where the need for this is identified through local audit risk assessments. Audit Scotland has prepared a series of best value toolkits to facilitate its reviews in these areas.

104. During the course of their audit appointment auditors should also consider and report on progress made by audited bodies in implementing the recommendations arising from reviews in earlier years.

105. This section includes a commentary on the best value/performance management arrangements within Highland Health Board. We also note any headline performance outcomes/measures used by Highland Health Board and any comment on any relevant national reports and the Board's response to these.

Management arrangements

Best Value

106. In March 2011, the Scottish Government issued new guidance for accountable officers on *Best Value in Public Services*. The guidance, in essence, required public bodies to take a systematic approach to self-evaluation and continuous improvement.

107. The guidance identifies the themes which an organisation needs to focus on in order to deliver the duty of best value, but notes that implementation should be appropriate and proportionate to the priorities, operating environment, scale and nature of the body's business.

108. The five themes and two cross-cutting themes (some of which we have commented on earlier in this report) are:

- vision and leadership
- effective partnership
- governance and accountability
- use of resources
- performance management
- equality (cross-cutting)
- sustainability (cross-cutting).

109. Guidance on the Best Value Framework was issued to Directors of Finance on 19 October 2011 from the Chair of the NHS Corporate Governance & Audit Group.

110. Highland Health Board is committed to the principles of best value and continuous improvement. The following sections provide more information on some of the ways the Board is addressing best value.

Best Value Toolkit - Efficiency

111. In our 2011/12 annual audit plan we highlighted that whilst the Board anticipated meeting its total efficiency savings target of £18.9 million for the year, a significant proportion of these efficiency savings would be non-recurring. This presents significant challenges for the Board in achieving the level of efficiencies required in the coming years and we planned to complete the Best Value - Efficiency toolkit to identify areas for improvement.

112. The Audit Scotland toolkits are a key part of the practical application of the best value audit and provide an evaluation framework which help auditors to reach robust judgements on how public bodies are delivering best value. The toolkits take the form of a series of key questions based on identified best practice. They set out four descriptors which capture levels of development or performance i.e. doesn't meet basic practice, basic practice, better practice and advanced practice.

113. Our findings were reported to the Audit Committee in June 2012. In summary this aspect of our work looked at five key areas:

- *How well does the organisational culture support improved efficiency?* The Board is moving towards better practice in this area.
- *To what extent is improved efficiency incorporated into the Board's vision?* A number of better practices are displayed in this area.

- *Are the Board's plans for measuring the scale of efficiencies achieved realistic?* The actions being taken are a strong indication of better practice in relation to realistic efficiencies
- *How does the Board gather the right information about efficiency plans to monitor progress?* Currently the Board meets the basic practice requirements in this area
- *How does the Board use information on progress to ensure planned efficiencies are attained or adjusted appropriately?* Overall we assessed the Board as being at the basic practice level at this stage but acknowledge that the stepping stones to improve are in place.

114. We concluded that the Board demonstrates a clear commitment to continuous improvement and delivery of best value. Whilst it has consistently delivered its target efficiency savings, the Board has relied heavily on the use of non-recurring savings to achieve this which is not sustainable in the longer term. The key challenges for the Board in the short term will be:

- focussing on the delivery of recurring savings
- fully utilising the costing information gathered by the costing system
- translating the information gathered through the various quality reviews into financial benefits to enable it to continue to deliver quality services with decreasing levels of funding.

115. We will continue to monitor the Board's activity in this area.

Service Redesign

116. Our annual audit plan highlighted that a key element of NHS bodies' response to the need to deliver high quality services in a challenging financial environment is to focus on the design and sustainability of its services. The Board has invested considerable time seeking improvement in the quality of patient care, and in tackling the causes of ill health through its Local Delivery Plan (LDP).

117. As part of service redesign, the Board appointed General Electrics (GE), an external LEAN contractor to work with it to deliver the change programme. A capacity strategy was developed to enable the Board to manage the pressures around improving patient outcomes, reducing costs and delivering efficiency. GE worked with the Board to deliver four service redesign projects. The final report provided by GE in March 2012 included the potential financial impact of the service redesign and the Board continues to move service redesign forward through its Strategic Framework which was approved in October 2010.

118. Highland Health Board is committed to its ambition of being person-centred, however it recognised that it is not always clear whether services are being delivered in a way that meets an individual's needs rather than organisational requirements. As a result the Board redesigned the Strategic Framework during 2011-12 to put the individual at the top of everything they do.

119. By continuing to focus on the quality of the care provided, through reducing unnecessary admissions, minimising stays in hospital, and striving to eliminate errors and infections, the Board aims to contribute to more efficient care and best use of resource. The Board has invested significant time in identifying the links between activity and cost within current service provision and is now looking to use this information to facilitate future service change.

Performance management

120. The Board has a well developed framework in place for monitoring and reporting performance. The Improvement Committee provides comprehensive board executive performance reports detailing performance against national HEAT targets and local priorities are submitted to the Board every two months.

121. Highland Health Board is subject to an annual review which is chaired by the Cabinet Secretary for Health and Wellbeing. The annual review highlights good performance and identifies areas where specific action would be required to improve health and treatment.

People Management

122. As with other health boards in Scotland, Highland Health Board faces a major challenge in achieving the national sickness absence target of 4%. The current sickness absence rate for the Board is 4.44% which is slightly lower than last year's rate of 4.8%. The Board has been effective in reducing its sickness absence year on year from a high of 5.03% in April 2008 and continues to push towards the national target.

Risk Area 9

123. It is important for Highland Health Board to have effective workforce planning arrangements in place in order to secure best value and meet challenging performance targets. The Board continues to develop its planning arrangements, including the Integrated Healthcare Strategy, to help ensure workforce plans are properly aligned to service and financial plans.

The Role of Boards – follow-up audit

124. The Role of Boards – follow-up audit was carried out in 2011/12 to assess the progress that Highland Health Board had made to improve the performance and operation of its Board against the recommendations made in Audit Scotland's national performance report '*The Role of Boards'* (September 2010).

125. In carrying out the study we used a checklist based on the key issues identified in the national report and this checklist was discussed with the Board Secretary who provided supporting evidence as appropriate. Our final report was issued to management in June 2012 and our findings indicate that good progress is being made in this area. The Board receives detailed information in relation to corporate performance, financial management and risk management on a regular basis in the form of an assurance report from the Improvement Committee. It also receive an annual report on the progress of the Single Outcome agreement in achieving the Scottish wide aims set out in Scotland Performs.

126. Other work to help improve the effectiveness of the Board included the following:

- a review of the existing governance arrangements has been carried out and revised structures were put in place on 1 April 2012.
- a review of training for board members has been carried out and a revised programme has been implemented.
- efforts have been made to include members of the public on committees wherever possible.

Using Locum Doctors in Hospitals- follow up audit

127. In June 2010 Audit Scotland published a report on 'Using Locum Doctors in Hospitals'. The report examined the reasons why NHS boards were using locum doctors and how much they were spending on them. In addition, the report considered whether NHS boards had appropriate arrangements in place for ensuring patient safety when using locum doctors. The report focused on the use of locum doctors in acute and community hospitals.

128. The 'Using Locum Doctors in Hospitals' report was presented to NHS Highland Performance Review Group on the 18th of January 2011. This included an assessment of how the Board was placed in relation to Audit Scotland's self-assessment checklist which was attached to the original report. The Board's internal auditors also carried out a follow up on the response to Audit Scotland's report which was published in August 2011.

129. As part of the 20011/12 audit we carried out a review of the Board's progress in the use of locums and the recommendations made in the 2010 report. Based on the original report, we focused our work on the following three questions:

- Can the NHS board show it is using locum doctors more efficiently?
- Is the NHS board managing demand for locum doctors effectively?
- How is the NHS board ensuring patient safety when using locum doctors?

130. We found that, whilst the Board is clearly committed to improving the arrangements over the use of medical locums, it still faces a number of challenges in addressing locum expenditure and patient safety issues. Progress has also been slow in implementing Internal Audit's recommendations with none of the seven actions agreed being implemented in full and only three have been partially implemented. All of these recommendations are now overdue against the target dates agreed with internal audit:

- The policy on the use of locum doctors has not been updated since the 2010 report was issued and therefore does not address all the current issues.
- There is still no consistent induction process in place for locum doctors. The absence of this process could impact on patient safety if locum doctors are taking up positions without being fully aware of all the systems in place within their department.
- Completion and retention of locum performance review information still requires to be developed to ensure that the Board has an overall picture of the performance of locums and to identify locum agencies which consistently provide poor performers.

- Information gathering and reporting on total expenditure on locum coverage (both internal and external) needs to be developed to give the Board a complete picture of spend in this area and to better identify the split between contract and non contract locum agencies.

131. We recognise that a number of the issues raised here reflect national concerns and that some work is being taken forward at a national level. However we would encourage the Board to speed up the implementation of all of internal audit's recommendations.

Risk Area 10

Overview of performance targets in 2011/12

132. The Board receives regular board executive performance reports from the Improvement Committee on progress towards achieving the key performance targets set by the Scottish Government (HEAT targets and standards) and local targets. The Board met all of the HEAT targets that were due in 2011-12, however, within Raigmore and North CHP, the financial performance and efficiency savings targets proved difficult to achieve.

133. The Board's performance in the current priority areas of waiting times, delayed discharges and healthcare associated infections are also monitored. Waiting times have been falling over recent years as the Board has achieved successive Government targets. The Government target is that from December 2011 the total maximum journey will be 18 weeks from referral to treatment. The Board has been achieving this target from June 2011.

134. The 2011/12 HEAT standard requires boards to have no patients waiting in excess of 6 weeks for discharge. As at March 2012, the Board reported that there were 4 patients whose discharge from hospital had been delayed in excess of 6 weeks. With effect from 1 April 2012, responsibility for delivery of adult social care transferred to the Board giving it greater ability to manage delayed discharges. Change fund monies will also be used to develop a number of services which will enable the Board to reduce admissions and/or facilitate early discharge.

135. In terms of Healthcare Associated Infection (HAI), the standards require boards to reduce HAIs so that by March 2013: staphylococcus aureus bacteraemia (SAB) cases are 0.26 or less per 1,000 acute occupied bed days; and the rate of Clostridium difficile infections in patients 65 and over is 0.39 cases or less per total occupied bed days. At March 2012, the Board reported that both these standards were currently being exceeded.

National performance reports

136. Audit Scotland carries out a national performance audit programme on behalf of the Accounts Commission and the Auditor General for Scotland. The findings and key messages of these studies are published in national reports.

137. The Board has a formal process to ensure that the findings of national reports relevant to the Board are considered in detail to identify their potential impact and the Board's progress in addressing recommendations locally. Action sheets accompanying each report are distributed under the auspices of the Audit Committee to relevant committees and subsequently

presented to the Board or one of the other Board sub-committees. Reports in the last year that may be of relevance to the Board include:

Table 2: A selection of National performance reports 2011/12

- Transport for Health and Social Care (Aug 2011)
- Scotland's Public Finances – Addressing the Challenges (Aug 2011)
- A Review of Telehealth in Scotland (Oct 2011) -
- Overview of the NHS in Scotland's performance 2010/11 (Dec 2011)
- Cardiology services (Feb 2012)
- Commissioning social care (Mar 2012)

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Transport for Health and Social Care

138. This report looked at the efficiency and effectiveness of transport arranged by the ambulance service, NHS boards and local authorities to take people to and from health appointments and social care services such as day centres. It also assessed how well agencies work together to plan and deliver transport for health and social care to meet local needs and identified examples of good practice and potential savings.

139. The report identified that transport services for health and social care are fragmented and there is a lack of leadership, ownership and monitoring of the services provided. The Scottish Government, Regional Transport Partnerships, local authorities, NHS boards and the ambulance service are not working together effectively to deliver transport for health and social care or making best use of available resources.

140. Highland Health Board takes part in HITS - the Highland and Islands Travel Scheme. This scheme provides non-means tested reimbursement for journeys for healthcare to people living in the Highlands and Islands. NHS Boards in these areas reclaim this money from the Scottish Government. The report highlighted that instead of individual reimbursements, money within this scheme could be more efficiently used for planned services such as community transport buses. The Board used this report when it was reviewing arrangements as part of the preparations for integration of adult and children's services.

Scotland's Public Finances – Addressing the Challenges

141. The report highlighted that Scotland's public sector budget in 2011/12 for running costs and day-to-day spending is £27.5 billion, a drop of 6 per cent or £1.7 billion in real terms from £29.2 billion in 2010/11. Public bodies have budgeted for this in 2011/12, but they need to make significant savings during the year and there is a risk they won't achieve this due to cost pressures being greater than expected or unforeseen events. Public bodies are facing increasing pressures and demands, such as Scotland's ageing population, the effects of the recent recession, and the public sector's maintenance backlog. Meanwhile budgets will continue to drop; the planned 2014/15 budget of £25.9 billion will be 11 per cent, or £3.3

billion, smaller than in 2010/11. Pay restraint and reducing workforces are the most common approaches being taken by public bodies to reduce costs over the next few years. Many bodies, including Highland Health Board, are already going through the process of reducing staff numbers through service redesign and further reductions are planned.

142. The position in Highland is, however, made more complex with the advent of the single agency model for adult and children's services which resulted in a net transfer of 1262 staff to Highland Health Board. Whilst this will distort staff numbers in 2012-13, the general trend at the Board is to reduce and restructure the workforce. We will continue to monitor developments in this area as part of the 2012/13 audit.

A Review of Telehealth in Scotland

143. This report highlighted the potential role of technology in improving the quality, delivery and efficiency of healthcare services. Since 2006, around 70 telehealth initiatives have been introduced but most of these are on a small scale. Given the fact that health services are facing a growing demand, new models of care such as telehealth should be considered to help manage this increasing demand. If targeted appropriately, telehealth offers the potential to help NHS boards deliver a range of clinical services more efficiently and effectively. Telehealth also offers a range of potential benefits for patients such as reducing travel, receiving a quicker diagnosis and avoiding hospital admissions. Patient experience is broadly positive with high levels of satisfaction and the experience is also a positive one for staff at NHS boards.

144. Highland Health Board is one of two Scottish Health Boards who are using telehealth in its widest range possible and have also put in place joint initiatives with island boards. Many of these initiatives use video conferencing as a means to provide access to healthcare for patients in remote areas. An example of this is the use of video conferencing to link the renal department in Inverness with renal dialysis units in Wick and Fort William for patient consultation.

145. We are currently carrying out a follow up exercise on this study to establish the impact it has had in each health board and whether areas for improvement are being addressed.

Overview of the NHS in Scotland's performance 2010/11

146. The report indicated that healthy life expectancy in Scotland has increased and rates of deaths from coronary heart disease, stroke and cancer continue to fall. However, overall life expectancy in Scotland remains lower than that of most other western European countries and there remain significant health inequalities and long-standing health-related problems such as obesity, smoking, and drug and alcohol misuse. The NHS in Scotland spent £12 billion in 2010/11 and all health bodies met their financial targets. However, ten of the fourteen territorial NHS boards reported underlying recurring deficits. The service faces pressures from an ageing population, rising public demand and expectations, increased costs and reducing staff. Although the budget for the NHS in Scotland in 2011/12 is £232 million higher than 2010/11, this is a reduction in real terms due to inflation.

147. NHS boards have strategies to make the service more efficient and effective and to help improve the quality of services it provides. Although information on hospital activity is good, the NHS in Scotland continues to find it difficult to measure productivity due to weaknesses in data and difficulties in linking costs, activity and quality. This is needed to identify how to improve services and the nation's health with the same or fewer resources. The Director of Finance has reviewed the key messages identified in the report to ensure they are reflected in the 2012/13 planning process.

Cardiology services

148. The report highlighted that there has been significant progress in tackling heart disease and developing services. Death rates have dropped by some 40 per cent during the past ten years while more patients are getting better treatments and waiting times have fallen. However, Scotland still has the highest rate of heart disease in Western Europe and the NHS in Scotland needs to ensure all patients get the services they need.

149. The specific actions recommended in the report are being taken forward by the Clinical Governance Committee.

Commissioning social care

150. This report looked at how well the public sector plans for, organises and delivers social care. Social care services range from supporting people with basic personal care such as washing and dressing to helping them with every aspect of their daily lives. People depending on these services include older people, vulnerable children, people with disabilities, and people with mental health problems, addictions or HIV/Aids.

151. The report stated that planning social care is complex and is becoming harder as demands are rising and budget constraints are tightening. A major change was the introduction of self-directed support that aims to give people a bigger say in the services they receive. This will require a new approach from local authorities and NHS Boards who must do more to involve both the people receiving services and the service provider organisations. If services are to improve better information is required on the needs of the population, on the costs, quality and impact of the services provided.

152. The report's recommendations included local authorities and NHS boards working together and referred to the Highland Health Board's Planning for Integration project as an example of such collaboration.

Outlook

Performance

153. Over recent years the Board has invested substantial resources in order to achieve challenging performance targets set by the Scottish Government. The significant financial challenges that will be faced in 2012/13 and beyond may require the Board to prioritise its resources. This will make maintaining or improving performance even more challenging.

154. In April 2011, the Equality Act 2010 introduced a new public sector 'General Duty' which encourages equality to be mainstreamed into public bodies' core work so that it is not a marginal activity but part and parcel of how public bodies operate. Following on from this the Scottish Government consulted on a set of 'Specific Duties' which came into force in May 2012. There are nine specific duties listed which aim to support public bodies to better perform against the 'General Duty,' including the duty to assess the impact of equalities in all policies and decisions as well as the requirement to publish a set of equality outcomes (and reporting requirements) no later than 30 April 2013. We will consider progress made by the Board in implementing these requirements as part our 2012/13 audit.

Appendix A: audit reports

External audit reports and audit opinions issued for 2011/12

Title of report or opinion	Date of issue	Date presented to Audit Committee
Internal Audit Reliance Letter	20 February 2012	13 March 2012
Annual Audit Plan	28 February 2012	13 March 2012
Best Value Toolkit: Efficiency	15 May 2012	18 June 2012
Internal Controls Management Letter	1 June 2012	18 June 2012
Report to Audit Committee in terms of ISA 260	15 June 2012	18 June 2012
Independent auditor's report on the financial statements	19 June 2012	18 June 2012
Role of Boards - follow-up	28 June 2012	11 September 2012 (planned)
Annual Report on the 2011/12 Audit	27 July 2012	11 September 2012 (planned)

Appendix B: action plan

Key Risk Areas and Planned Management Action

Action Point	Refer Para No	Risk Identified	Planned Management Action	Responsible Officer	Target Date
1	*18*	***Non current assets*** The Board's gross cost and accumulated depreciation figures in the annual accounts were adjusted downwards by £44 million due to incorrect treatment of revaluation adjustments in previous years. Assurances were provided that the non current asset note had been accurately stated in 2011-12. Work is still required to provide similar assurances to the Board on the detail included in the Revaluation Reserve. ***There is a risk that errors exist within the Revaluation Reserve as a result of the previous treatment of revaluation adjustments.***	A reconciliation of the Revaluation Reserve to non current assets in both the ledger and the fixed asset register provides the assurance that the treatment of the revaluation has been applied correctly and only the annual accounts template from previous years had been an issue. As agreed a rolling reconciliation will be held in year to provide the guarantee required that any future revaluations have been actioned appropriately.	Director of Finance	On-going

Action Point	Refer Para No	Risk Identified	Planned Management Action	Responsible Officer	Target Date
2	***24***	***Equal Pay*** Highland Health Board (along with other boards) has not been able to quantify the extent of its liability for Equal Pay claims. ***There is a risk that these liabilities will have a significant impact on the Board's financial position.***	Maintaining links with Scottish Government Finance Department to keep up to date with SGHSCD / CLO progress.	Director of Finance	On-going
3	***25***	***Agenda for Change*** A provision of £1.246 million was included in the 2011-12 accounts for expected arrears payments to employees within the scope of the Agenda for Change pay modernisation agreement. The level of provision deemed sufficient by the Board is 20% of the calculated figure ***There is a risk that this provision may not be sufficient to meet successful claims.***	The provision was calculated using advice and information available. The calculation for the level provided was agreed for senior bands within Nursing, Midwifery and Allied Health Professionals using specific criteria where this was seen to be the highest risk area. The provision will be continually monitored and revised if required in year.	Director of Finance	On-going

Action Point	Refer Para No	Risk Identified	Planned Management Action	Responsible Officer	Target Date
4	***27***	***Surplus Sites Agreement*** The Board's balance sheet includes a debtor balance of £6.226 million in respect of anticipated income from remaining undeveloped sites. ***There is a risk that, given the current economic climate and the reduction in land values that the income due from the site may not be fully realised.***	We will continue to have on-going contact and seek professional advice from the Chartered Surveyors dealing with these sites to ensure the figure in the accounts is realistic.	Director of Finance	On-going

Action Point	Refer Para No	Risk Identified	Planned Management Action	Responsible Officer	Target Date
5	***48*** ***50***	***2012/13 Savings Target*** The Board faces a wide range of financial challenges in delivering the LDP and Quality Improvement agenda***.*** ***There is a risk that the Board may not be able to make its savings targets in 2012/13. The longer term financial plan remains at risk of not being affordable and is a significant challenge to the Board moving forward.***	NHS Highland has agreed an approach to efficiency based on improving quality by reducing harm and waste and managing variation. It is recognised that this approach takes time to deliver cash-releasing savings and it is acknowledged that 'traditional' cost reduction programmes will need to be followed at the same time. The efficiency targets have been allocated to units (with the exception of £4.5m being pursued on a 'system-wide' basis across northern Highland). Regular reporting arrangements are in place (to Board, Senior Management Team and the Improvement Committee) and in particular the Improvement Committee is taking an active performance management role on this agenda***.***	Chief Executive	On-going

Action Point	Refer Para No	Risk Identified	Planned Management Action	Responsible Officer	Target Date
6	***83***	**IT equipment** Currently the data network is fit for purpose, although the Board's tight CRL may lead to some items continuing in use past their normal lifecycle. This could lead to sudden hardware failures or memory upgrade being required to maintain an appropriate level of service delivery. ***There is a risk that the data network may not remain fit for purpose in the longer term.***	While it is accepted that funding is tight there is contingency in place to deal with any network failures. The Head of eHealth maintains a contingency fund as an element of the overall eHealth strategy funding and there is also the option to access overall capital contingency funding if required. To date it has not been necessary to access either source of funding on an emergency basis.	Head of eHealth	On-going
7	***84***	**eHealth risks** The eHealth risk included in the risk register were not identified through a formal risk assessment process therefore may not be all of the risks faced by the department. ***There is a risk that the Board may not be aware of technology risks and therefore does not take appropriate action.***	The eHealth risk register was recently established to supplement the existing detailed project specific risk register. The eHealth risk register has, to date, been used as an internal document and remains in development. It is agreed that the process will be further formalised and that a formal risk assessment will be applied to all identified risks within the eHealth environment resulting in the production of a more comprehensive risk register.	Head of eHealth	31/3/12

Action Point	Refer Para No	Risk Identified	Planned Management Action	Responsible Officer	Target Date
8	***89***	***Annual Report*** NHS boards are required to produce an annual report outlining performance for the year. In 2010-11 Highland Health Board moved away from a glossy report to a newsletter which was delivered to all houses in the area. However, the newsletter did not include any financial information. ***There is a risk that the Board does not comply with all aspects of the Scottish Government guidance on annual reports published in 2007.***	Future versions of the newspaper will address this issue.	Head of Public Relations & Engagement	31/12/12
9	***122***	***Sickness Absence*** The Board has been effective in reducing its sickness absence year on year from a high of 5.03% in April 2008 to 4.44% in 2012. Whilst it continues to push towards the national target of 4% this has not yet been achieved. ***The Board may not achieve the target of 4%, which could impact on the achievement of financial and non-financial performance targets, such as waiting times targets.***	There will be continued monitoring of sickness absence data on a monthly basis with data provided to managers. There will be continued quarterly case reviews of employees on long term sickness. There will be on-going Promoting Attendance workshops and events to support appropriate management action.	Director of Human Resources	On-going

Action Point	Refer Para No	Risk Identified	Planned Management Action	Responsible Officer	Target Date
10	***131***	***Use of Locum Doctors*** Whilst the Board is clearly committed to improving the arrangements over the use of medical locums, it still faces a number of challenges in addressing locum expenditure and patient safety issues. In addition it has not delivered on agreed recommendations for improvement agreed in the 2011 internal audit report ***There is a risk that the Board is not achieving best value in the use of locums and patient safety may be at risk if locum doctors do not perform to acceptable standards.***	The Board accepts the recommendations made by internal audit and will prioritise taking this forward using a project management process with our medical workforce redesign manager.	Head of Recruitment & Employment Services	31/12/12