Highland Health Board

Annual report on the 2012/13 audit

AUDIT SCOTLAND

Prepared for Highland Health Board and the Auditor General for Scotland
July 2013

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Key Messages

2012/13 Key Facts

The Scottish public sector is experiencing significant financial challenges in providing expected levels of service within the agreed financial framework. In 2012/13 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 findings.

Financial Statements

We have given an unqualified audit report on the financial statements of Highland Health Board for 2012/13. 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.

Financial position and use of resources

The Board achieved all of its financial targets in 2012/13 and returned a saving against its total Revenue Resource Limit of £0.273 million as at 31 March 2013. Total efficiency savings of £23.736 million have been delivered in 2012/13 (planned savings £23.8 million). However, £13.841 million of these savings were on a non recurring basis. As a result of this, the savings target for 2013/14 is £18.37 million of which £12.37 million are expected to be recurring savings and £6 million non recurring savings. It is important that the Board achieves these targets as carrying forward unachieved recurrent savings is unsustainable in the longer term.

The total capital budget increased from £12.965 million in 2011/12 to £13.351 million in 2012/13. The capital budget was higher this year as additional funding was provided by the Scottish Government for the implementation of energy efficient measures including biomass boilers and solar panels.

Governance and accountability

In 2012/13, the Board had sound governance arrangements which included a number of standing committees overseeing key aspects of governance. These included Audit, Staff Governance, Clinical Governance and Improvement Committees. The Board also had an effective internal audit function and anti-fraud arrangements.

A key Scottish Government Policy remains the drive towards heath and social care integration across Scotland and Highland has been a pioneer in this respect with the introduction of a single lead agency arrangements for Adult Community Care Services (Highland Health Board) and for Children's Services (the Highland Council). It was recognised from the outset that establishing the agreement was just the first stage and there would be a period of redesign which would see services evolving in an integrated way. As with any significant change in service delivery, there is a high degree of risk until the new working practices and processes are embedded and the first

year of the new arrangement has brought a number of challenges which continue to be worked through.

Performance and best value

In 2012/13 the Board met or exceeded a number of performance targets set by the Scottish Government. However, the Board has not achieved its performance targets in some areas such as the referral to drug treatment target and access to specialist care for stroke patients.

Audit Scotland's report on the management of patients on NHS waiting lists following reported misuse of patient unavailability codes at another NHS Board found that only limited information could be extracted from the Highland Health Board's systems, and there was evidence of patients with periods of social unavailability with no end date. A local review of waiting times carried out by internal audit also identified some areas for improvement. The Board provided written assurance to the Scottish Government that improvement actions identified by internal audit had either been implemented or were in progress.

Outlook

The position going forward is becoming even more challenging than previous years with limited increases in funding, increasing cost pressures and challenging savings targets. To achieve continuing financial balance the Board will require to deliver significant savings in 2013/14. This will make maintaining or improving on the performance targets set by the Scottish Government challenging.

In this context, the Board faces a number of performance challenges not least the maintenance of access targets. The new 12 week Treatment Time Guarantee, which is now a legal requirement (from 1 October 2012), requires significant resources to achieve and sustain and the Board has developed a recovery plan to achieve compliance by the end of the first quarter of 2013/14.

Introduction

1. This report is the summary of our findings arising from the 2012/13 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 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 2012/13 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 2012/13 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 addressed this requirement 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. The unaudited accounts template was provided to us on 7 May 2013 supported by a comprehensive working papers package. The template was substantially complete at that date with only capital commitments and SFR18 information outstanding. However, the narrative sections of the accounts including the Directors Report, Operating and Financial

Review, Financial Performance and Position, Performance against Key Non Financial Targets, Sustainability and Environmental Reporting, Remuneration Report, Statement of Chief Executive's Responsibilities, Statement of Board Members' Responsibilities and Governance Statement were not made available until 23 May 2013. Capital commitments figures were not received until 15 June 2013.

Risk Area 1

15. The good standard of supporting papers and the efforts of finance staff to provide responses allowed us to conclude our audit within the agreed timetable and provide our proposed opinion to the Audit Committee on 27 June 2013 as outlined in our Annual Audit Plan.

16. A number of presentational and monetary adjustments were identified within the financial statements during the course of our audit. These were discussed with senior finance officers who agreed to amend the unaudited financial statements. The effect of these adjustments was to increase expenditure in the Statement of Comprehensive Net Expenditure by £3.3 million (see paragraph 19 below) and decrease net assets as recorded in the balance sheet by £0.715 million.

17. Two monetary errors were identified during the audit, where if adjusted would have had a net effect of increasing operating costs by £30,700 for the year, shown in the Statement of Comprehensive Net Expenditure. The net impact on the balance sheet would have been to decrease net assets by £30,700.

18. As required by auditing standards we reported to the Audit Committee on 27 June 2013 the main issues arising from our audit of the financial statements. The main points were:

Pension costs

19. Following the transfer of 1620 staff from Highland Council, the Board became an admitted body of the Highland Council Pension Fund and as such was required to include details of the pension costs, assets and liabilities for these staff in line with International Accounting Standard 19 - Employee Benefits. This is based on an actuarial calculation and requires a report to be provided by the Fund's actuaries. The initial actuarial report received included an opening liability of £19 million for the transferred staff, however, this liability related to their employment at The Highland Council prior to 1 April 2012 and it had been agreed this would be retained by the Council. A revised actuarial report was requested which resulted in a pension gain of £1.311 million from the initial report becoming a pension liability of £1.287 million in the revised report. This is the first year that the Board has incurred an IAS19 liability, which is a technical accounting adjustment and is subject to fluctuations year on year depending on the actuarial assumptions applied (see also paragraphs 56 to 68).

20. The accounts were amended to reflect the revised IAS19 impact as per the actuarial valuation. This is being funded through annually managed expenditure and is shown as "other reserves" in the balance sheet. This is not a usable reserve.

21. Following national guidance from the Scottish Government, Note 24 of the accounts (*Pension Costs*) reflects a Scotland-wide net liability of £370 million for the NHS Superannuation

Scheme arising from the most recent actuarial valuation for the year 31 March 2004. A more recent actuarial valuation was carried out at 31 March 2008, but the publication of this valuation has been 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 costs. There is therefore a risk that the Board's costs may increase once the latest valuation of the NHS Superannuation scheme is made public.

Risk Area 2

Surplus Sites

22. In 2000 Highland Health Board 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.

23. As at 31 March 2013, £5.926 million of accrued income was recognised in the Board's financial statements in respect of anticipated income from the remaining undeveloped sites. This amount was based on professional advice from chartered surveyors Montagu Evans on the likely income that would be achieved for each of the sites. The Board has also provided assurances that this amount, in their judgement, represents a prudent estimate of anticipated income. The estimate is based on an assessment of future income at the time each of the sites is developed. The criteria are consistent across all the sites and based on market valuation of the sites, a subjective assessment informed by the best information available. Due to the current economic climate and continuing uncertainty surrounding the property market it is important that the level of realisable income is kept under review and we will continue to monitor progress in relation to these surplus sites.

Maternity Leave

24. On 29 May 2013 Boards were notified of a Scottish Terms and Conditions Council decision that women health workers in Scotland were to receive five years (backdated) public holidays they had been entitled to whilst on maternity leave. The impact of this to Highland Health Board was estimated to be £0.9 million. A provision was established for this cost and additional annually managed expenditure funding received from and repayable to the Scottish Government Health and Social Care Directorate (SGHSCD).

Fruitless payment: Capital Resourcing Limit (CRL) impact

25. At year end two capital schemes were deemed fruitless although £17,700 had been incurred on them. This was one of the unadjusted errors referred to at paragraph 17 above. As a result the CRL was overstated by this amount. Had this error been adjusted the Board would have had an underspend of £17,700 on its CRL.

Equal Pay Claims

26. The National Health Service in Scotland has received in excess of 9,000 equal pay claims and by the end of March 2013 there remained 246 grievances registered against NHS Highland. These have been referred for the attention of the NHS Scotland Central Legal Office (CLO) to co-ordinate the legal response to this issue.

27. SGHSCD, the CLO and Audit Scotland met in March 2013 to review the accounting treatment and disclosure requirements for the 2012/13 accounts. The CLO continues to advise that it is not possible to provide any financial quantification of Equal Pay Claims at this stage because of the lack of information available. Given the CLO's advice, the SGHSCD have notified NHS boards that the appropriate accounting treatment is to disclose the claims as a contingent liability although with an expanded disclosure recognising the developments over the last couple of years.

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

Risk Area 3

Outlook

Endowments

29. As a result of an agreed derogation from the FReM NHS Scotland boards were not required to consolidate endowment funds within their 2012/13 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. The consolidation process will be reviewed as part of our audit of the 2013/14 financial statements.

Financial position

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

31. 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.

32. 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 2013

33. Highland Health Board is required to work within the resource limits and cash requirement set by the SGHSCD. In 2012/13, the SGHSCD required NHS boards to differentiate between core and non-core expenditure for both revenue and capital. The Board achieved all its financial targets in 2012/13 as outlined in the table below:

Table 1: 2012/13 Financial Targets Performance £'000s

Financial Target	SGHSCD limit	Actual	Variance
Revenue Resource			
Core	554,607	554,334	273
Non Core	27,554	27,554	0
Capital resource			
Core	13,109	13,109	0
Non Core	242	242	0
Cash position			
Cash requirement	605,000	604,546	454

34. There are various movements in the allocation during the year. The Board's initial allocation letter in June 2012 included a core RRL of £561,325,187 and a core CRL of £8,300,000. The Board has achieved a cumulative surplus of £0.273 million against its final core RRL allocation. The Board had budgeted to break-even against its Revenue Resource Limit in

2012/13. Despite the small surplus, in 2012/13 the Board recorded an underlying deficit of £7.29 million, which represented the excess of recurring expenditure commitments, over recurring funding and savings, carried forward into 2013/14. 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 (see also paragraphs 41 to 47 below).

Capital Resource Limit

35. The Board reported a breakeven position against its total Capital Resource Limit (CRL) in 2012/13 with total capital expenditure of £13.351 million. The total capital allocation was made up of core capital funding to the value of £13.109 million and non-core funding of £0.242 million.

36. The key areas of capital expenditure in 2012/13 included approximately £2 million on energy efficient equipment (biomass boilers and solar panels) and £0.815 million on medical equipment. In addition, £0.135 million was spent improving facilities at Kyle Court with a further £0.3 million on the purchase of land to facilitate the development of a new health centre at Tain.

Financial planning to support priority setting and cost reductions

37. The key focus for the Board is its quality agenda which is central to its mission statement "quality care to every person every day". The Board has set out a very clear vision through its Local Delivery Plan (LDP) and the Highland Quality Approach (HQA) to:

- provide quality care at all times
- support people and communities to maximise their own health
- develop precision driven services so that when people need care they experience timely focussed, effective services that minimise the duration and frequency of contact
- ensure that every health pound spent delivers maximum health gain.

38. A lot of time and resource has been invested into the quality agenda and ensuring staff are kept up to date with developments. The Board is aiming to fully embed HQA in 2013/14. This commitment to quality is coupled with a need to achieve efficiencies. All senior managers will be tasked with leading on a review project aimed at improving operational, clinical, and management processes (Lean approach). The challenge to the Board is to evidence that the investment in the quality agenda is translated into both the delivery of its strategic plan and achievement of efficiency savings.

Workforce Reduction

39. The Board saw a significant increase in staff numbers this year as a result of integrated health and social care services (refer paragraphs 56 to 68 below). Nevertheless, it is committed to

ensuring that workforce reductions are contributing to efficiency savings, for example, through the Scottish Government targets to reduce senior management by 25% over the period 2010 to 2014. The Board is currently preparing its workforce plan 2013/14 which will focus on workforce development and workforce contribution to quality improvement and service redesign with the ultimate aim of improving patient care and service provision. The plan will consider changes in demographics of both patients and staff over the long term. It is anticipated that this will be presented to the Board in August 2013.

Agency Costs

40. There was a large increase in agency costs during 2012/13, with costs increasing from £3.67 million to £5.28 million, a rise of over 40%. Agency staff are required for a variety of reasons including cover for senior vacant posts. However, as agency costs are higher than those for staff on permanent contracts it will be difficult to achieve the required savings targets if this increased reliance on agency workers remains unchecked.

Risk Area 4

Outlook

Financial sustainability and the 2013/14 budget

41. Uplifts in financial settlements have been reducing in recent years as outlined below:

Table 2: General funding uplift 2009/10 to 2012/13

Financial Year	General Uplift
2009/10	3.15%
2010/11	2.15%
2011/12	1.1%
2012/13	1.0%

42. Looking forward, the indications are that funding uplifts are likely to be around 2.8% in 2013/14 and 2.7% in 2014/15. Given the current economic conditions and the impact of national spending priorities, there is a risk that these pressures will have a significant impact on long term financial planning.

43. The cost challenges facing the Board are significant and in some cases there is an element of uncertainty about further potential increases in costs. In 2012/13 the Board's cost savings plan reported in the 2012/13 LDP was pivotal to achieving financial balance. The plan set a cost savings target of £23.8 million and the Board achieved £9.895 million savings on a recurrent basis and £13.841 million on a non-recurrent basis (a total of £23.736 million). The Board has relied heavily of non-recurring savings in recent years but this is not a sustainable position in the longer term. Within its 2013/14 LDP the Board acknowledges the need to focus on returning to financial balance on a recurrent basis which is expected to be achieved over

the next three financial years, with an estimated underlying deficit of £6 million at the end of 2013/14.

44. The Board plans to break even in 2013/14 but its ability to achieve financial balance is again largely dependent on successfully developing and implementing a comprehensive cost savings plan. For 2013/14, the Board needs to achieve £12.37 million of recurring cost savings (£18.37 million in total) which is the equivalent to 2.1% of the Board's core revenue resource allocation of £584.353 million. This represents a major challenge to 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.

45. The Board continues to face significant cost pressures relating to the rate of growth in anticipated prescribing costs, along with anticipated inflationary increases in workforce costs during 2013/14.

46. All additional expenditure will require to be met from the Board's existing resource and as a result any significant fluctuations in these costs will present a major challenge to Highland Health Board achieving financial balance for the coming year. The cost savings are to be achieved through a number of means, including continued service redesign, strict vacancy management, more efficient procurement practices and a continued focus on primary care prescribing costs.

47. The delivery of the cost savings plan in 2013/14 will remain challenging and failure to achieve planned cost savings will impact on the Board's ability to achieve a break even position.

Risk Area 5

Governance and accountability

48. 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.

49. 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.

50. 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.

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

Corporate governance

Processes and committees

52. 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:
    - Audit Committee
    - Clinical Governance Committee
    - Staff Governance Committee
    - Improvement Committee.

Patient safety and clinical governance

53. Overall, clinical governance is within the remit of the Clinical Governance Committee. The Committee provides assurance to the Board that the principles and standards of clinical governance are applied to health improvement and protection across the Highlands. Patient safety is at the heart of clinical governance and risk management. The Healthcare Environment Inspectorate has a key role in helping NHS boards reduce the risk of Hospital Associated Infection (HAI) in acute hospitals through assessment, inspection and reporting of boards' performance against HAI standards.

54. The Healthcare Environment Inspectorate (HEI) carried out 6 visits (1 announced and 5 unannounced) visits to the Board's hospitals. There were 2 unannounced visits to Raigmore. The report issued in August 2012 had 9 requirements and 2 recommendations to improve practices particularly in relation to cleanliness. In the follow up report issued in January 2013 the chief inspector reported that HEI were encouraged by the progress which had been made in achieving standards to protect patients from the risks of HAI and reported on the good standard of cleanliness of wards and departments.

55. Overall the inspections found that the Board was complying with the majority of standards to protect patients, staff and visitors from acquiring an infection. Action plans from the other four inspections have been agreed and are being progressed:

- Lorn & Islands General Hospital (Announced) 18 April 2012 - whilst some areas for improvement were highlighted, overall staff were aware of their role and responsibilities in relation to infection prevention and control, and there was good awareness and implementation of isolation procedures for patients with known infections.
- Belford Hospital (Unannounced) 8 May 2012 - whilst this found that the hospital was clean and policies were up to date, further improvement was required to ensure that all staff groups implement all standard infection control precautions
- MacKinnon Memorial Hospital (Unannounced) 10 May 2012 - this found that the Board needed to ensure all staff understand and implement standard infection control precautions at all times, particularly in relation to the use of personal protective equipment
- Caithness General Hospital (Unannounced) 3-4 September 2012 - improvements required related to formally allocating cleaning duties and responsibilities for domestic staff, and having an effective system to make sure patients receive information about infection prevention and control

Partnership Working/Lead Agency Agreement

56. A key Scottish Government Policy remains the drive towards heath and social care integration across Scotland. Partnership working is actively being promoted by the Scottish Government as a means of making service delivery more efficient and cost effective.

57. Highland has been a pioneer in this respect. In May 2011, the 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 (Highland Health Board) and for Children's Services (the Highland Council). Both bodies have joint responsibility for specifying the outcomes to be achieved and the total resources allocated to these two service areas.

58. The Partnership agreement was signed by representatives of both authorities on 21 March 2012 ahead of the new arrangements commencing 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.

59. Planning for integration had been on-going for 15 months before the April target date and it was recognised from the outset that this was just the first stage of a period of redesign which would see services evolving in an integrated way. The on-going process will involve all stakeholders and focus on developing new ways of service delivery that reflects a commissioning approach and focusses on the agreed outcomes. This is being managed through the Integrating Care in the Highlands programme.

60. Governance arrangements to scrutinise the delivery of services by both lead agencies have been put in place. A Strategic Commissioning Group was also established, involving senior members of the Board and Council, as well as the chief executives, senior officers, third sector partners and staff side representatives. This Group reports to both the Board and the Council on the agreed performance indicators for commissioned services and makes refinements to these as required.

61. As with any significant change in service delivery, there are higher risks until new working practices and processes are embedded. Front-line operational services were the key focus during the year, but support services were not given the same emphasis. Advice and support from the Scottish Government on how to deal with differing approaches to support services is being sought.

62. The adult social care budgets transferred from The Highland Council are large and complex and the final figure of £89 million was not fully agreed until March 2013. The partnership agreement tasks both directors of finance with agreeing the treatment of any budget variances. As this agency agreement evolves and budgets are more clearly understood there may be a need for more formal arrangements to be agreed to address differences that arise.

63. For 2013/14, it has been agreed that uplifts received from the Scottish Government for adult and children's services will be passed on in full. The Board received an uplift of 2.8% for children's services for the year and the Council received a zero uplift in respect of adult services. The Scottish Government expects all public sector bodies to deliver an efficiency saving of at least 3% and both the Board and Council will be mutually accountable for complying with this requirement in respect of the delegated services.

64. In view of the flat cash settlement relating to Adult Social Care services, it is evident that savings will be needed to cover price inflation (including pay awards and contract inflation) as well as demographic pressures. The Board has acknowledged that significant savings will be required if it is to deliver a break-even position in 2013/14 and has included £3.7 million savings in the 2013/14 budget for adult services.

65. As highlighted at paragraph 19, 1620 staff transferred from the Council to the Board and, under the partnership agreement, this group of staff stayed within the Local Government pension scheme. As a result the Board became an admitted member of the Highland Council Pension Fund which is a defined benefits scheme and requires significantly more accounting disclosures than the NHS Superannuation scheme which is treated as a defined contributions scheme. It resulted in a pension liability of £1.3 million being brought onto the Board's balance sheet.

66. Highland Council care homes were used by the Board under a license to occupy agreement in 2012/13 and work is currently underway to determine a longer term arrangement for the use of these facilities.

67. Information management and technology is one of the most complex aspects of the on-going work and a recent internal audit report highlighted that eHealth has not progressed as anticipated. It is expected that the appointment of a project manager in May 2013 and the development of a longer term project plan will be key to getting this aspect of the integration work back on track.

68. As part of the integration process, the Board's CHP structure was reorganised. The three CHPs (North, Mid and South-East) whose geographical locations are coterminous with The Highland Council's geographical area were merged into one to form the Highland Health and Social Care Partnership (HH&SCP) which includes Raigmore Hospital as a separate unit. 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. The Board is now putting forward plans to integrate health and social care in Argyll & Bute CHP. An implementation date has been set for 1 April 2014 for integration of adult and children's social care between Argyll & Bute CHP and Argyll & Bute Council.

Internal control

69. 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. The extent of this work is informed by their assessment of risk and the activities of internal audit.

70. 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 2012/13, the Board's internal auditors Scott Moncrieff provided their opinion that, based on the internal audit work undertaken during the year, there were three areas which would indicate a likely requirement for disclosure in the 2012/13 governance statement. These related to financial management at Raigmore, adherence with the new Patient's Records Act (2013) and the Board's risk management strategy.

71. As part of our audit 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 trade payables, trade receivables, cash and cash equivalents, payroll, general ledger, capital accounting and family heath services. Our overall conclusion was that Highland Health Board had adequate systems of internal control in place in 2012/13. A few risk areas for improvement were agreed with management to improve the controls within the payroll and trade payables systems. In addition, we highlighted different working practices across the Boards 2 delivery units (HH&SCP and A&B CHP) which should be monitored to ensure these do not adversely affect the Board's ability to accurately record and report.

72. Our interim work highlighted cases of the payroll and trade payable delegated level of authority (DLA) limits not being fully adhered to. During year end testing we found this was also the case in relation to expense claim forms. In addition, for 4 of the 7 forms tested, the appropriate supporting documentation (e.g. MOT and up to date insurance certificates) was not held. A new process for expenses will be introduced in June 2013, and staff will be expected to produce MOT certificates etc.

73. Accounting journals are the mechanism for recording transactions in the general ledger. Evidence for these is kept in either hard copy showing evidence of approval or electronic copy although this does not evidence that the approver has reviewed the journal. The ledger system (eFin) does not provide the primary control (segregation between preparing, authorising and posting) for journals. In discussions with officers it was agreed that evidence of journal authorisation will be retained and the option to implement the authorisation facility on eFin will be explored.

Internal Audit

74. 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). The review of internal audit was carried out in March 2013 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.

75. We also placed formal reliance on the work of internal audit, for the purposes of our financial statements audit, in two specific areas: procurement and payroll (relating to the transfer of staff through integration). This not only avoided duplication of effort but also enabled us to focus on other areas of risk.

Governance Statement

76. 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. Additionally, the governance statement includes the requirement for an overt assurance that arrangements have been made to ensure best value.

77. The Board disclosed several areas of weakness in the expected standards for good governance as highlighted at paragraph 66 above (risk management, Raigmore financial management and paper records management). In each case the Board has put plans in place to ensure adherence or improvement in these areas throughout 2013/14. The statement also highlighted that appropriate arrangements for Best Value are in place. Our audit has confirmed that we concur with this assessment.

eHealth

78. During 2012/13 the Board's eHealth department has taken forward a number of significant information technology projects, the largest being TRAK (also referred to as TRAK Care,

Patient Management System (PMS) and Intersystems). In addition business-as-usual improvements to the infrastructure to improve resilience and convergence between the Argyll & Bute and Northern Highland networks are ongoing.

79. The eHealth forward delivery plan is based on the national eHealth Strategy and covers the period 2011 to 2014. eHealth management periodically meets with the Scottish Government to discuss the progress in meeting the objectives of the local delivery plan. Delivery against targets is ongoing, although some aspects (for example the Clinical Portal and the implementation of the privacy alert system Fairwarning) are being delayed somewhat due to outside influences.

80. In our Internal Controls Assurance Report we raised a concern that access to systems and information held electronically is not well controlled, in particular that access rights of staff who have left are not suspended timeously. The importance of good controls over access to electronic information, in light of information assurance, cannot be stressed enough. This importance will be stressed again as a responsibility of all managers. We are also hopeful that the new electronic human resources system (eEES) will be able to assist in improving this area.

NHS Boards Annual Reports

81. 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. However, the Scottish Government has issued guidelines detailing information which should be included in the annual report

82. Since 2010-11 Highland Health Board has 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 does not include:

- summary financial statements or a link to the full financial statements.
- details of the Annual Review letter from the Health Secretary.
- complaints information/statistics.
- details of all inspectorate (HEI) visits nor information on how to obtain copies of the HEI reports.

Risk area 6

Prevention and detection of fraud and irregularities

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

84. Highland Health Board has a range of measures in place to prevent and detect fraud, including Standing Financial Instructions, a Code of Conduct for staff and a number of other policies that are available to staff via the intranet including 'whistleblowing'. 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.

85. The Board's internal audit function has a formal programme of work, which, although not designed to detect fraud, does provide assurance on the operation of the control systems which are designed to prevent fraud. In addition, the Board has agreed a formal protocol covering a programme of payment verification checks within the Practitioner Services Division of NHS National Services Scotland.

86. We concluded that the Board's arrangements were adequate in relation to the prevention and detection of fraud and irregularities, although it should be noted that no system can eliminate the risk of fraud entirely.

NFI in Scotland

87. Highland Health Board participates in the National Fraud Initiative (NFI). The NFI 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.

88. NFI allows public bodies to investigate these matches and, if fraud or error, has taken place, to stop payments and attempt to recover the amounts involved. It also allows auditors to assess the arrangements that the bodies have put in place to prevent and detect fraud, including how they approach the NFI exercise itself.

89. The most recent data matching exercise collected data from participants in October 2012 with matches identified for follow-up in February 2013. The investigation so far has identified matches in both the creditors and payroll systems.

90. We have been advised that the Board has a plan in place to review its NFI matches, but we found that little progress had been made to date in reviewing matches.

Risk Area 7

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

91. 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.

92. The Board has a Code of Conduct for Board Members that is based on the Ethical Standards in Public Life etc. (Scotland) Act 2000. This includes a register of interests. Furthermore, the Board is currently updating its fraud procedures to include a specific paragraph on the Bribery

Act 2011and its requirements. We have concluded that the arrangements for the prevention and detection of corruption at Highland Health Board are satisfactory, subject to any updates, and we are not aware of any specific issues that we need to identify in this report.

Equality Act 2010

93. 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 of everyday business.

94. Highland Health Board has worked to ensure that the duties under the Equality Act have been used to further the Highland Quality Approach's aim of Better Health, Better Care and Better Value. The Board's Mainstreaming Equality (published April 2013) sets out the progress and plans made by the Board in meeting the requirements of integrating equality. This is being achieved in a number of ways, including:

- Allocation of overall responsibility for equalities issues to two senior managers (one responsible for HR issues, the other for all other equalities matters).
- Training programmes including online and face to face training are available to give more staff the opportunity to hear about and discuss first hand experiences regarding equality and diversity.
- Mandatory requirement for all staff to complete the Equality & Diversity: Core Principles course. Other equalities learning sessions are offered to reflect organisational need and opportunity e.g. with local community group Highland Rainbow Folk and participate in deaf awareness sessions.
- Communication of equality issues through the intranet, internet and staff newsletter.
- The establishment of regular board updates regarding equality.

95. Under the Equality legislation, the Board is required to publish information about its equality outcomes, the actions taken and the progress made to achieve these. This is to allow the public to assess the organisation's performance on equality. In keeping with legislation the Board must review its outcomes every 2 years; therefore the first review will be by April 2015.

Outlook

Partnership Working

96. Between 2011/12 and 2014/15 the Scottish Government's spending will fall by 5.5% (£1.5 billion) allowing for inflation. Reductions of this scale are a significant challenge for the Scottish Public sector. The Christie Commission report on the future of public services (June 2011) highlighted the need for a new, more radical, collaborative culture throughout Scotland's public services with a much stronger emphasis on tackling deep-rooted and persistent social problems in communities.

97. There is now a renewed focus on partnership working focused on community planning. Audit Scotland's recent report on Improving community planning in Scotland (March 2013)

highlighted that community planning has had little influence over mainstream public sector budgets and other resources used to date. The Scottish Government has re-emphasised the central role that community planning should play in driving the reform of public services. Indeed, the 'Statement of Ambition' published by the Scottish Government and the Convention of Scottish Local Authorities sets out high expectations of community planning and puts the community planning process at the core of public service reform by providing the foundation for effective partnership working, within which wider reform initiatives will happen. The increasing importance of partnership working within a community planning framework is still evolving and we will monitor progress in this area.

98. The Public Bodies (Joint Working) (Scotland) Bill was published on 29 May 2013 and sets out the legislative structure to integrate health and social care services. As highlighted at paragraphs 56 to 68 above the Board (and The Highland Council) have already implemented an approach across Highland. Other NHS boards, councils, Scottish Government and regulators will undoubtedly look to the Highland example to identify both pitfalls and benefits from the approach taken. It is currently too early to comment on how successful the integration of care programme in the Highlands has been, however this is expected to be a key aspect to delivering quality services. We will continue to monitor progress in this area.

Best Value, use of resources and performance

99. Accountable officers have a specific responsibility to ensure that arrangements have been made to secure Best Value.

100. 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.

101. 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.

102. 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.

103. 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.

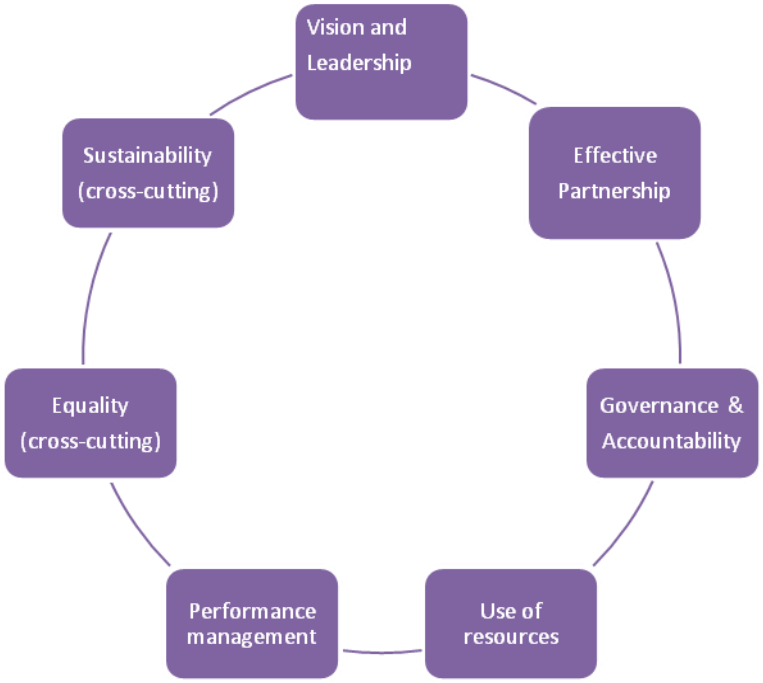
104. This section includes a commentary on the Best Value / performance management arrangements within Highland Health Board. We also note any headline performance outcomes / measures used by Highland Health Board and any comment on any relevant national reports and the Board's response to these.

Management arrangements

Best Value

105. In March 2011, the Scottish Government issued new guidance for accountable officers on Best Value in Public Services. It required public bodies to take a systematic approach to self-evaluation and continuous improvement. Furthermore, the guidance identifies the seven themes which an organisation needs to focus on in order to deliver the duty of Best Value. It also notes that implementation should be appropriate and proportionate to the priorities, operating environment, scale and nature of the body's business.

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



107. Highland Health Board is committed to the principles of Best Value and continuous improvement. During the year the Board developed a best value assurance framework to map activities and sources of assurance against the Scottish Government's best value themes. This framework will be updated on a continuous basis. We will continue to monitor developments in this area.

Service Redesign

108. The main drive in relation to service redesign this year was the introduction of the pioneering lead agency approach to integrating health and social care - refer paragraphs 56 to 68 for more details.

Performance management

109. 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.

110. 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

111. As with other health boards in Scotland, Highland Health Board faces a major challenge in achieving the national sickness absence target of 4%. In our 2011/12 report we highlighted that the Board had been effective in reducing its sickness absence year on year from a high of 5.03% in April 2008 and continued to push towards the national target. In 2012/13 the sickness absence rate was 4.9% which was slightly higher than the previous year's rate of 4.5%. In discussions with officers we were advised that the increased number of staff following integration of adult services was one of the most significant factor as this group of staff brought over a higher instance of sick leave.

Risk Area 8

Scotland's Public Finances – Addressing the challenges

112. In the current year, we carried out a focussed follow-up audit on *Scotland's public finances: addressing the challenges* report originally published in August 2011. Follow-up audits are also being carried out in all health boards and councils in Scotland and at 20 central government bodies, including the Scottish Government, Scottish Enterprise and Scottish Water.

113. The original report set out a number of key issues and risks expected to be faced by the public sector in the period 2010/11 to 2014/15. The main aim of the follow-up audit is to look at what action has been taken since the publication of the original report in August 2011 and what difference this has made.

114. A key consideration in the Audit Scotland report was the extent to which workforce reductions were being used to deliver financial savings. This was not covered by the follow-up audit because of a separate study being carried out by Audit Scotland on changes to the Scottish public sector workforce which will look in detail at workforce planning.

115. During the year we also applied the Audit Scotland Planning and Resource Alignment best value toolkit to assess the Board's arrangements at a strategic level and how these are used to deliver improved outcomes. This element of our work considered the overall vision and objectives of the Board and the resources required to deliver on these. As both reviews considered financial planning the findings were combined for reporting purposes.

116. This element of our audit work focussed on the following key questions:

- Does the organisation demonstrate effective strategic planning and resourcing of its activities to deliver its vision? (BV Toolkit)
- Does the organisation have a well developed planning framework that ensures effective integration of strategy and resources? (BV Toolkit)
- Do public bodies have sustainable financial plans which reflect a strategic approach to cost reduction? (Follow up SPF)
- Do senior officials and non-executive directors demonstrate ownership of financial plans and are they subject to sufficient scrutiny before approval? (Follow up SPF)

- Does the organisation's approach help deliver outcomes? (BV Toolkit)

117. Overall we found that the Board demonstrates a clear commitment to continuous improvement. In line with national planning requirements, financial plans covering a five year period are included in the Local Development Plan. These take account of cost reductions and other efficiency savings required and show a breakeven position year on year. They do not detail how the plans will be achieved. The five year financial forecasts are very high level and later years are subject to a number of caveats.

118. Strategic plans are by their nature, high level and generally take a top down approach. Operational service plans are, therefore, required detailing specific objectives and milestones to deliver the strategic plans. We noted that the Board is currently in the process of drafting operational unit delivery plans to address this need.

119. With the continuing requirement to identify efficiencies and deliver quality services there is a risk that planned savings are undeliverable. In 2012/13 the overall savings target was £23.8 million. Savings can be either recurrent or non-recurrent and there has been a heavy reliance on non-recurring savings at the Board in recent years (58% of total savings in 2011/12, 55% in 2012/13). This results in higher savings being required in future years.

120. Benchmarking costs and performance with other private and public organisations can be a valuable tool for identifying efficiencies and improvements. The Board does not currently carry out any benchmarking exercises with external organisations nor does it make use of the ISD National Benchmarking Project: National Efficiency and Productivity which focusses on identifying efficiency and productivity opportunities.

121. The requirement to break-even year on year results in a short-term focus on financial planning within the NHS. The Board does not have contingency plans in place to address the longer term risks identified and it is not clear what the on-going impact on priorities and outcomes will be.

122. An Internal Audit Capacity Planning report in 2013 highlighted that the Board had not included specific, measurable, achievable, relevant and timely (SMART) actions in its strategic documents therefore it was not always clear what specific actions were required, by when and who would have responsibility for delivering on these actions. The scrutiny approach could be strengthened by including SMART actions in future.

123. The challenge for the Board going forward will be to develop detailed long term plans to manage performance in light of the strategic risks being faced; particularly as the financial constraints within the public sector are expected to continue for the foreseeable future.

Overview of performance targets in 2012/13

124. 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.

125. The Board has achieved good performance by either meeting or exceeding its targets in a number of areas. These include for example, decrease in delay in discharging patients from hospital; timely appointments for ante-natal care and targeted child healthy weight interventions.

126. Some targets were not fully achieved. These include the referral to drug treatment target and access to specialist care for stroke patients. Maintaining and sustaining access targets is resource intensive and costly. This increases the pressure on the Board at a time when it is requires to achieve significant savings on a recurrent basis.

Risk Area 9

127. The Patients Rights (Scotland) Act 2012 introduced a statutory 12 week treatment time guarantee for eligible patients. This became effective from 1 October 2012. Whilst the Board did not achieve this standard in a number of cases a recovery plan was developed with a view to achieving compliance by the end of June 2013.

National performance reports

128. 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.

129. There is formal process in place 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 2012/13

- Management of patients on NHS waiting lists (February 2013)
- Prescribing in general practice in Scotland (January 2013)
- Health inequalities in Scotland (December 2012)
- NHS Financial Performance 2011/12 (October 2012)

www.audit-scotland.gov.uk

Management of patients on NHS waiting lists

130. Audit Scotland carried out a review of waiting times across the health service in Scotland following NHS Lothian's reported misuse of patient unavailability codes. The review recognised the need for independent assurance on the management of waiting times to restore public confidence in the system.

131. In addition, NHS boards' internal auditors were requested by the SGHSCD to carry out a review of waiting times as part of their 2012/13 internal audit plans and to report their findings

by 17 December 2012. Shortly after this date, the Cabinet Secretary for Health and Well Being reported to the parliament the findings from internal audits carried out across the NHS in Scotland. The main findings were:

- there is no evidence of wide scale manipulation of waiting times across the National Health Service in Scotland
- overall, the waiting times published by boards are reliable and accurate
- the principal shortcomings relate mostly to the capability to record on some information technology systems, the consistent interpretation of guidance, and staff training
- there are specific, localised issues in board areas that need to be addressed.

132. The Cabinet Secretary also made clear that he expected NHS boards to have implemented all locally identified recommendations for improvement by March 2013.

133. The internal auditors for Highland Health Board reported their findings to the Audit Committee on 4 December 2012. They found that there was no indication of the existence of systematic and deliberate mis-recording or mis-reporting of waiting times which would materially impact on achievement of waiting times targets. However, in a small number of cases tested, inconsistencies were identified in the implementation of the waiting times guidance which resulted in the avoidance of a breach against the 18 week Referral to Treatment target, when correct implementation of the guidance would have resulted in a breach. Internal Audit concluded that, from wider analysis and extended sample testing undertaken (including focussing on suspensions applied to journeys near to breaching), this would not appear to have a high risk of a material impact on reporting against waiting times targets.

The internal audit report identified some areas for improvement including:

- For a period of patient unavailability (i.e. a patient is “suspended” from the waiting list) staff should record sufficient detail of why the unavailability is being applied
- Audit trail capabilities in place within the North Highland patient management system should be sufficiently robust to ensure inappropriate changes are not made to patients records.
- System access privileges should be reviewed to ensure that access is commensurate with user roles and responsibilities.
- The local access policy should be reviewed and updated against revised national guidance and regulations.

134. The SGHSCD have requested that all boards undertake a follow-up audit on the management of waiting times to ensure that planned improvements have been made and are working effectively. We will monitor the position at a future date. Management agreed an action plan of improvements which were subsequently reviewed in more detail by the Audit Committee in March 2013 to confirm progress in implementation as requested by the Cabinet Secretary. These enabled the Chairman of the Audit Committee to provide a letter of assurance to the

Scottish Government's Health and Wellbeing Audit and Risk Committee that local improvements had been implemented or were in progress.

135. Audit Scotland's report on the *Management of patients on NHS waiting lists* published in February 2013 highlighted similar issues to those outlined above:

- The systems used to manage waiting lists have inadequate controls and audit trails, and the information recorded in patient records is limited.
- Most patients' records that were examined did not include enough information to verify that unavailability codes had been applied properly
- Audit Scotland identified a small number of instances in which unavailability codes were used inappropriately. The limitations of waiting list management systems and the lack of evidence in patient records mean that it is not possible to determine whether these instances were due to human error, inconsistent interpretation of the guidance, or deliberate manipulation of waiting lists.
- There was not enough scrutiny of the increasing number of patients recorded as unavailable.

136. The national report also highlighted the following issues in relation to the Board:

- "The information we were able to extract from the iSoft system used by NHS Highland was extremely limited
- With the exception of systems in NHS Greater Glasgow and Clyde and NHS Highland, NHS boards had systems with audit trails in place that can identify unusual activity.
- NHS Highland had patients with periods of social unavailability with no end date. This means patients could have remained unavailable indefinitely if they were not reviewed."

Prescribing in general practice in Scotland

137. The overall aim of this national report was to examine prescribing in General Practices across NHS Scotland and identify the potential to improve prescribing economy, efficiency and effectiveness

138. The report highlighted that the NHS in Scotland spends almost £1.4 billion per year on drugs, of which almost £1 billion (70 per cent) is spent in general practice. Two territorial NHS boards spend about ten per cent of their budgets on GP prescriptions and boards continue to identify this as a significant cost pressure.

139. The report noted that NHS Scotland has improved its management of GP prescribing and family doctors are getting more support and guidance on their prescribing. The report, however, indicated that there was further scope for improvements and the potential to save up to £26 million per annum without affecting patient care. The savings could mostly be achieved through reducing waste and cutting the use of less suitable medicines.

140. Highland Health Board has undertaken an assessment of GP prescribing costs which analysed the impact of new drugs, increases in volumes and the impact of drugs coming off patent during the year with a view to managing this demand led cost.

Health inequalities in Scotland

141. Reducing health inequalities has been a priority for successive governments in Scotland with the introduction of major legislation supporting this aim, such as the ban on smoking in public places and minimum pricing for alcohol. The Scottish Government's spending review reiterated its commitment to addressing health inequalities, and allocated around £170 million to NHS boards to directly address health-related issues associated with inequalities.

142. The national performance report assessed how well public sector bodies are working together to target resources at health inequalities. The report indicated that it was unclear how much money NHS Boards and Councils spend in this area or what it is spent on. Furthermore, the report highlighted that the Scottish Government takes account of deprivation and other local needs in allocating funding to NHS Boards and Councils. However, it is not clear how these bodies target their resources at local areas with the greatest need. Within the Highland Health and Social Care locality, funding allocated for health inequality is weighted above the Scottish average for rurality and deprivation.

NHS Financial Performance 2011/12

143. The report provides an overview of the financial performance of the NHS in Scotland during financial year 2011/12. It also highlights the financial sustainability, challenges and cost pressures facing the NHS.

144. The report notes that after several years of growth in public finances following devolution, public sector budgets are now falling. This reinforces the need for sound financial management and clear financial reporting, underpinned by good information and strong governance and accountability.

145. In 2011/12, spending on health accounted for about a third of the total Scottish budget and amounted to around £11.7 billion. Although the overall health budget has continued to increase in cash terms, it has been decreasing in real terms since 2009/10 and is projected to decrease further in real terms for the next three years.

146. The Scottish Government allocates over 90% of the total health budget to 23 NHS boards, with the remainder retained by the Scottish Government to spend on other areas of its Health and Wellbeing Portfolio. While the overall health budget is decreasing in real terms, the Scottish Government has protected the total amount allocated to territorial boards and this will increase slightly in real terms (1.3 per cent) over the next three years. However, budgets for special boards will fall by 5.6 per cent in real terms.

147. The national report noted that the NHS in Scotland continued to manage its finances within total budget. However, this does not reflect the pressures faced by boards and a number of them had to rely on non-recurring savings to achieve balance. Moreover, some other boards needed extra help from the Scottish Government to break-even in 2011/12.

148. Boards are increasingly reliant on achieving savings to meet their financial targets yet across the NHS 20% of savings plans are considered high risk although some boards are indicating that they will have to achieve savings in excess of this level.

149. The national report highlighted that Highland Health Board's non recurring savings were more than 40% of its overall savings in 2011/12. Whilst the Board has continued to rely on non recurring savings in 2012/13 it recognises the need to deliver recurring savings (refer paragraph 43 above). The introduction of the Highland Quality Approach is the focus for achieving this.

Outlook

Performance

150. The Auditor General has been asked by the Public Audit Committee of the Scottish Parliament to provide an update on Audit Scotland's Management of patients on NHS waiting lists report later this year. The audit work will focus on progress made by the NHS in establishing clear information audit trails and on the management and monitoring of waiting lists. The fieldwork for the report will be carried out at NHS boards in September and October of 2013 with a report to the Public Audit Committee by the end of December 2013.

Appendix A: audit reports

External audit reports and audit opinions issued for 2012/13

Title of report or opinion	Date of issue	Date presented to Audit Committee
Annual Audit Plan	19 February 2013	12 March 2013
Internal Controls Management Letter	31 May 2013	27 June 2013
Scotland's Public Finances: Follow Up (incorporating Best Value Toolkit: Planning & Resource Alignment)	24 May 2013	27 June 2013
Report to Audit Committee in terms of ISA 260	20 June 2013	27 June 2013
Independent auditor's report on the financial statements	27 June 2013	27 June 2013
Annual Report on the 2012/13 Audit	July 2013	10 September 2013 (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	14	**Draft Accounts** The unaudited accounts template was provided to us (substantially complete) on 7 May 2013 supported by a comprehensive working papers package. However, the narrative sections of the accounts including the Directors Report, Operating and Financial Review and Remuneration Report were not made available until 23 May 2013. ***There is a risk that the accounts will not be audited by the 30th June deadline if the draft accounts are not provided timeously.***	The delay in 2012/13 was caused by an extended period of unplanned sickness for a key member of staff. Additional support was drafted in to support the achievement of the ultimate deadline and if there is a need to provide additional resources to achieve this in future, this will be closely monitored.	Director of Finance	On-going

Action Point	Refer Para No	Risk Identified	Planned Management Action	Responsible Officer	Target Date
2	21	**NHS Superannuation Scheme** Note 24 of the accounts reflects a Scotland-wide net liability of £370 million for the NHS Superannuation Scheme. This is based on an actuarial valuation as at 31 March 2004. A more recent valuation has still to be published which could impact on the level of employer and employee contributions to the Scheme. ***There is a risk that the Board's costs may increase once the latest valuation of the NHS Superannuation scheme is made public***.	Maintain links with SGHSCD/SPPA regarding progress with this - the impact will affect all NHS Boards in Scotland.	Director of Finance	On-going
3	28	***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.***	Maintain links with SGHSCD/CLO regarding progress with these claims.	Director of Finance	On-going

Action Point	Refer Para No	Risk Identified	Planned Management Action	Responsible Officer	Target Date
4	40	**Agency Costs** There has been a large increase in agency costs during 2012/13. Costs increased from £3.67 million to £5.28 million, a rise of over 40%. ***There is a risk that required savings targets will not be met if there is increased reliance on agency workers***	The Board has a continual focus on locum agency use and spend including - a Locum Policy - reference in Workforce Plan with specific action plans to address risks - engagement with the National Reshaping Medical Workforce Group. - Local Unscheduled Care Action Plan - locum use is a standing agenda item on staff governance committee - on-going work with a number of partners to mitigate against increasing locum agency costs and - on-going national work to address workforce shortages in small specialties	Director of Human Resources	On-going

Action Point	Refer Para No	Risk Identified	Planned Management Action	Responsible Officer	Target Date
5	47	**13/14 Savings Target** The delivery of the cost savings plan in 2013/14 will remain challenging and failure to achieve planned cost savings will impact on the Board's ability to achieve a break even position. ***There is a risk that the planned savings target will not be achieved.***	Regular reviews and monitoring of the delivery of savings will take place throughout the year via the Directors of Operations Group including agreeing any corrective actions necessary. This will be reported through the Senior Management Team, Health and Social Care Committee and ultimately, the Board.	Director of Finance and Chief Operating Officer	On-going
6	82	**Annual Report** NHS boards are required to produce an annual report outlining performance for the year. Since 2010/11 the Board has issued a newsletter to every home in the area. However, the newsletter did not include any financial information, details of the annual review with the Health Secretary, details of inspection reports or complaints. ***There is a risk that the Board does not comply with all aspects of the Scottish Government guidance on annual reports published in 2007***.	The newsletter will go out 3 times per year with links to the electronic versions on the NHS Highland website for full information on the annual accounts, annual review and inspection reports. First newsletter expected October 2013.	Head of Public Relations & Engagement	October 2013.

Action Point	Refer Para No	Risk Identified	Planned Management Action	Responsible Officer	Target Date
7	90	**National Fraud Initiative (NFI)** The Board participates in the NFI which identifies circumstances (matches) that might suggest the existence of fraud or error. We found that, to date, little progress had been made in reviewing notified matches. ***There is a risk that fraudulent activity is not timeously identified and stopped.***	The audit finding of little progress is based on the NFI website. Our review has been undertaken 'off line' to date and is described below. Our intention is to present a paper to the September 2013 Audit Committee outlining the findings and action taken. Many matches relate to multiple contracts (either within or outwith) the NHS Highland area and these reflect bank working alongside substantive contracts. We are satisfied from our checks that these do not constitute fraud but assist in identifying excessive working hours in terms of Working Time Regulations. We have also looked at a random sample of such staff taking sick leave with Highland and shared this with other employers to assess possible sick pay fraud. A review of VAT issues has also been carried out but there is more work to be done on creditors matches.	Head of Area Accounting	Sept 2013 (for report to Audit Cttee) and follow up work as required until close of the 2012/13 exercise.

Action Point	Refer Para No	Risk Identified	Planned Management Action	Responsible Officer	Target Date
8	111	**Sickness Absence** Staff numbers at the Board increased by around 1500 (net) in 2012/13 following the move to integrated health and social care services. With increased staffing levels there has been an associated increase in sickness absence during the year to 4.9% (increase of 0.4%) ***There is a risk that the Board may not achieve the sickness absence target of 4% which could impact on its ability to achieve its financial and non financial performance targets***.	Sickness absence trends have increased slightly partly as a result of inheriting a higher level of long term sickness absence through local authority staff transferred to NHS Highland. Long term sickness absence is analysed every 6-8 weeks A regular audit of long term cases is undertaken to ensure early and appropriate interventions. Transferred staff only became the responsibility of NHS Occupational Health Services from April 2013 and are now supported on an equal basis.	Director of Human Resources	31 March 2014
9	126	**Performance targets** The Board did not achieve all its performance targets in 2012/13. ***There is a risk that in a climate of reducing funding and competing priorities, performance targets are not achieved and sustained.***	Continuous monitoring by the Improvement Committee and reporting to the Board will continue with appropriate actions agreed to achieve targets.	Chief Operating Officer	On-going