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NHS Western Isles

Annual report to Those Charged with Governance and the Auditor General for Scotland

Final

Year ended 31 March 2015

June 2015

141 Bothwell Street
Glasgow
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The Healthcare Governance and Audit Committee
NHS Western Isles
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25 June 2015

Ladies and Gentleman,

We are pleased to enclose our report to the Healthcare Governance and Audit Committee in respect of our audit for the year ended 31 March 2015. The primary purpose of this report is to communicate the significant findings arising from our audit that we believe are relevant to those charged with governance.

The scope and proposed focus of our audit work was summarised in our audit plan, which we presented to the Healthcare Governance and Audit Committee in February 2015. We have subsequently reviewed our audit plan and concluded that our original risk assessment remains appropriate. The procedures we have performed in response to our assessment of significant audit risks are detailed in Section 2.

We have completed our audit work and expect to be able to issue an unqualified audit opinion on the financial statements on 25 June 2015. At the time of writing, the key outstanding matters, where our work has commenced but is not yet finalised, are:

- Representation letters; and
- Subsequent events review.

We will provide an oral update on these matters at the meeting on 25 June 2015.

We look forward to discussing our report with you on 25 June 2015. Attending the meeting from PwC will be Martin Pitt.

Yours faithfully

PricewaterhouseCoopers LLP

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Section 1. Executive summary

Introduction

We set out in this report our significant findings from our audit of NHS Western Isles ("the Board") for 2014/15, together with those matters which auditing standards require us to report to you as "those charged with governance" of the Board.

We carried out our audit work in line with our 2014/15 audit plan that we presented to you on 4 February 2015. Our audit is not designed to identify all matters that may be relevant to you. Accordingly, the audit does not identify all such matters. 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.

Framework for Our Audit

Our audit is conducted in accordance with Auditing Standards (International Standards on Auditing ('ISAs') (UK and Ireland)) and the Code of Audit Practice ('the Code').

The Code explains how external auditors should carry out their functions under the Public Finance and Accountability (Scotland) Act 2000. The audit of financial statements is covered by engagement and ethical standards issued by the UK Auditing Practices Board (APB), so the Code focuses more on the wider functions of public sector auditors. We have conducted our audit in accordance with the relevant requirements of the Code.

Respective Responsibilities of Management and Auditors

Management

It is the responsibility of the Board and the Chief Executive, as Accountable Officer, to prepare the financial statements in accordance with the National Health Service (Scotland) Act 1978 and directions made there under. This means:

- acting within the law and ensuring the regularity of transactions by putting in place systems of internal control to ensure that financial transactions are in accordance with the appropriate authority;
- maintaining proper accounting records;
- preparing financial statements timeously which give a true and fair view of the financial position of the Board and its expenditure and income for the year ended 31 March 2015; and
- preparing a Directors' Report, a Strategic Report, a Governance Statement and a Remuneration Report.

Auditors' responsibilities

Our responsibilities in accordance with the Code of Audit Practice are to provide you with an audit report, stating whether, in our opinion the financial statements and the part of the Remuneration Report to be audited and give an opinion on:

- whether they give a true and fair view of the financial position of the Board and its expenditure and income for the year;
- whether they were prepared properly in accordance with relevant legislation, applicable accounting standards and other reporting requirements;
- whether the information which comprises the annual report included with the financial statements is consistent with the financial statements; and
- whether expenditure and receipts have been incurred and applied in accordance with guidance from Scottish Ministers (the regularity opinion).

We are also required to review and report as necessary on other information published with the financial statements, including the directors' report, annual governance statement, statement on internal control or statement on internal financial control and the remuneration report.

Financial Statements

As a result of our work, we proposed a number of disclosure audit adjustments to the draft financial statements. No financial adjustments were proposed as a result of our work. There are no unadjusted misstatements at the conclusion of our audit, as these have been resolved and accepted by management.

We have completed the majority of our audit work and expect to be able to issue an unqualified audit opinion on 25 June 2015.

Financial performance

The Board's key financial performance for the year is as follows:

- In the year the Board had a final outturn of £76.043m against its core revenue resource limit of £74.045m, achieving an underspend of £2,000 (2013/14: £3,000).
- The Board achieved a breakeven position (2013/14: saving of £3,000) against its Core Capital Resource Limit of £1.566m.
- The Board also achieved its cash releasing efficiency savings target of £2.139m. 90% of the Board's efficiency savings were made through recurring savings, with £223,000 (10%) identified through non-recurring sources.

Other Matters

We have discussed the following other matter within this report:

Clinical Negligence and Other Risks Indemnity Scheme (CNORIS) Provision

An additional CNORIS provision of £583,000 has been recognised in the 2014/15 accounts to recognise the liability for a future payment that it is probable that the Board will incur based on its share of the overall provision required for NHS Scotland. The value of this second provision for both 2014/15 and 2013/14 has been determined by the Scottish Government and communicated as such to the Board. This is in addition to the Clinical and Medical negligence provision which has previously been recognised and which amounted to £885,000 as at 31 March 2015.

Please see Section 2 below for details.

Please note that copies of this report will be sent to Audit Scotland in accordance with their requirements.

We thank the management and staff of the Board for their co-operation and assistance during the course of our work.

Section 2: Significant audit and accounting matters

We have set out in this section the significant matters arising from our audit.

Matters identified in our audit plan

Set out below is a summary of our response to matters identified in our audit plan:

Matter arising	Audit response
Fraud and management override of controls – Significant Risk ISA (UK&I) 240 requires that we plan our audit work to consider the risk of fraud, which is presumed to be a significant risk in any audit. In any organisation, management may be in a position to override the financial controls that you have in place. The current economic conditions may also increase fraud risk.	• We tested the appropriateness of a journals with a focus on those of a higher risk nature; • We examined management's accounting estimates for bias and in particular performed detailed testing over accruals and provisions; • We performed unpredictability testing over a sample of immaterial staff and patient expenses claims incurred in 2014/15 to ensure that the claims were appropriate and had been recognised in the correct period. **We did not identify any issues to report to you as a result of our work.**

<table>
<tr><th>Matter arising</th><th>Audit response</th></tr>
<tr><td>Recognition of income – Significant Risk
Under ISA (UK&I) 240 there is a (rebuttable) presumption that there are risks of fraud in revenue recognition. There is a risk that the Board could adopt accounting policies or treat income transactions in such a way as to lead to material misstatement in the reported revenue position.

Because of the fact that the focus for NHS bodies is on how funding is expended, we extend this presumption to the recognition of expenditure in the NHS (please see below).</td><td>• We evaluated and tested the accounting policy for income recognition to ensure that it is consistent with the requirements of the International Financial Reporting Standards (IFRSs), as adopted by the European Union, and as interpreted and adapted by the 2014/15 Government Financial Reporting Manual (FReM);
• We obtained an understanding of key revenue controls in place within the board;
• We performed substantive testing on a sample of transactions from each material category of revenue and confirmed with reference to supporting documentation that each was recorded at the correct value, in the correct accounting period and was posted correctly within the accounts;
• We identified high risk manual journals posted to revenue accounts, including significant value revenue journals and journals impacting an unusual combination of account codes, and identified the rationale for these transactions; and
• We reviewed intra-NHS confirmations of balances between other health boards.

We did not identify any issues to report to you as a result of our work.</td></tr>
<tr><td>Recognition of expenditure– Significant Risk
We extend the above presumption of risk of fraud in revenue recognition to the recognition of expenditure in the NHS.

In the current economic climate, all NHS Boards are required to deliver significant efficiency savings and are also under scrutiny in relation to financial sustainability.</td><td>• We evaluated and tested the accounting policy for expenditure recognition to ensure that it is consistent with the requirements of the International Financial Reporting Standards (IFRSs), as adopted by the European Union, and as interpreted and adapted by the 2014/15 Government Financial Reporting Manual (FReM);
• We performed substantive testing on a sample of transactions from each material category of expenditure and confirmed with reference to supporting documentation that each was recorded at the correct value, in the correct accounting period and posted correctly within the accounts;
• We identified high risk manual journals posted to expenditure accounts and identified the rationale for these transactions; and
• We reviewed estimates for expenditure, including accruals and provisions, to ensure that these were accounted for on an accurate basis and in the correct period.

We did not identify any issues to report to you as a result of our work.</td></tr>
</table>

Materiality

We have conducted our work in accordance with the materiality levels detailed below. These figures have been based upon actual results for the year and therefore differ from those reported in our audit plan. We have applied a de-minimus level of £84,483, which was agreed with the Healthcare Governance and Audit Committee upon submission of our annual audit plan.

	£
Overall materiality – This is the amount we have applied in assessing the overall impact on the financial statements of potential adjustments	1,689,660
Performance materiality - We have applied this to direct the amount of work performed over each financial statement line item – for example in calculating sample sizes	1,267,245
De-minimus posting level - Under ISA (UK & I) 450, we are required to report to the Audit Committee on all unadjusted misstatements in excess of a 'de-minimus' or 'clearly trifling' amount	84,483

Other Areas of Audit Focus

In addition to the significant risks described above, we also identified the following area of accounting treatment during the course of our work that we wish to draw to your attention.

Clinical Negligence and Other Risks Indemnity Scheme (CNORIS) Provision

The Clinical Negligence and Other Risks Indemnity Scheme (CNORIS) has been in operation since 2000. Participation in the scheme is mandatory for all NHS Boards in Scotland. The scheme allows for risk pooling of legal claims in relation to clinical negligence and other risks and works in a similar manner to an insurance scheme. CNORIS has an agreed threshold of £25,000 and any claims with a value less than this are met directly from within Boards' own budgets. Boards contribute to the CNORIS pool each financial year at a pre-agreed contribution rate based on the risks associated with their individual organisation. If a claim is settled the Health Board will be reimbursed by the scheme for the value of the settlement, less a £25,000 "excess" fee.

When a legal claim is made against an individual Health Board, the Central Legal Office (CLO) will make an assessment of the likelihood of the claim being successful and this dictates the level of provision required (either 0, 50% or 100%). Any remaining balance not provided for will be recognised as contingent liability. If a provision is required then the Health Board should also create an associated receivable recognising reimbursement from the scheme if the legal claim settles.

In the current year, Scottish Government has advised that Health Boards should also recognise that they will be required to make contributions to the scheme in future years. Therefore a second provision that recognises the Health Boards' share of the total CNORIS liability of NHS Scotland has been calculated by the Scottish Government and allocated to each Health Board for recognition within the annual accounts.

In relation to the first provision, as in prior years, the Board has recognised a CNORIS provision. The value of this provision as at 31 March 2015 was £885,000 (2013/14: £185,000). This figure is derived from details of outstanding claims as provided to the Board by the CLO. We have confirmed that this provision is in agreement with the latest correspondence received from the CLO. Additionally, the associated receivable recognising the reimbursement from the scheme has been created. This amounts to the value of the settlement, less the £25,000 "excess" fee for each claim and as at 31 March 2015 was £613,000.

In relation to the second provision, Scottish Government guidance issued to the Board during 2014/15 indicated that the Board was required to recognise a provision of £583,000 as at 31 March 2015. In addition a restatement of prior year balances was also required in order to disclose the secondary provision as at 31 March 2014 of £523,000 and as at 31 March 2013 of £766,000. We have confirmed these balances directly with the Scottish Government. Audit Scotland has also assessed Scottish Government's method of allocating the overall provision

between Boards and found no issues with this methodology. We are satisfied the Board has made the relevant prior year restatements and disclosures to account for this new provision.

We can confirm that our work did not identify any errors that required adjustment to the financial statements.

Related parties

In forming an opinion on the financial statements, we are required to evaluate:

- whether identified related party relationships and transactions have been appropriately accounted for and disclosed; and
- whether the effects of the related party relationships and transactions cause the financial statements to be misleading.

It is a requirement of International Accounting Standard 24 that transactions with related parties are identified and disclosed in the financial statements. In the context of the Board, related parties would include Directors and Senior Management and their close family members.

NHS Western Isles obtains annual related parties declarations from Board members. This was used by the Board as the basis for identifying related parties.

As part of the audit process, we performed audit procedures to confirm that related party declarations were complete and that the related party disclosure within the accounts was also complete.

Misstatements and significant audit adjustments

We report to you all misstatements that we have found during the course of our audit, other than those of a trivial nature, which have not been corrected by management in the financial statements. There are no such unadjusted misstatements to report. No financial adjustments were proposed during the course of our audit.

Qualitative aspects of accounting practices

Improving the quality of NHS annual report and accounts

In December 2014 Audit Scotland published good practice note *'Improving the quality of NHS annual report and accounts'*. The overarching objective of the publication was to help all boards improve their accounts presentation. Audit Scotland identified the following main causes of poor presentation by NHS Boards as follows:

- Over-reliance on the template provided by the Scottish Government;
- Inclusion of irrelevant disclosures; and
- A lack of attention to detail in preparation of the accounts.

As part of our audit work we have completed the good practice checklist within the publication and have no matters to bring to your attention.

Financial statement disclosures

We have also reviewed, and tested, the material disclosures in the financial statements. We identified no significant issues as part of this work. A number of disclosure adjustments were identified during the course of our audit but these were all resolved and accepted by management.

Governance Statement

The Financial Reporting Manual requires Chief Executives to sign a Governance Statement which covers all controls including financial, operational, compliance and the management of risk. The Scottish Government

Health and Social Care Directorate (SGHSCD) has issued *Guidance on Governance Statements 2014/15* to help Chief Executives prepare their Board's Governance Statements.

We reviewed the governance statement and considered the following:

- Compliance with the required elements of the proforma statement developed by SGHSCD; and
- Consistency with the remainder of information presented within the annual accounts and our overarching understanding of the entity.

Based on our normal audit procedures, we do not disagree with the disclosures contained in the Statement.

Section 3. Financial performance

Financial targets

The Scottish Government Health and Social Care Directorates set three financial targets for the Board on an annual basis. These targets are:

- Revenue Resource Limit – a resource limit for ongoing operations;
- Capital Resource Limit – a resource budget for net capital investment; and
- Cash requirement – a financing requirement to fund the cash consequences of the ongoing operations and net capital investment.

The Board's performance against its three financial targets for financial year 2014/15 is set out below:

Table 1: Financial targets summary 2014/15

	Limit as agreed by SGHSCD £ 000	Actual Outturn £ 000	Underspend/ (Overspend) £ 000
Revenue Resource Limit (RRL)			
Core	76,045	76,043	2
Non-core	2,427	2,427	-
TOTAL	**78,472**	**78,470**	**2**
Capital Resource Limit (CRL)			
Core	1,756	1,756	-
Cash Requirement			
Cash Requirement	78,000	77,690	310

The underspend for the year 14/15 is £2,000 against the limit agreed by the Scottish Government Health and Social Care Directorate (SGHSCD). The key variances were as follows:

- Overspend of £663,000 on the Hospital and Mental Health Medical budgets due to the need to employ locums to cover staff vacancies and sickness;
- Overspend of £327,000 on Acute Nursing Budgets and Hospital Administration due to higher bed occupancy caused by delayed discharges;
- Overspend of £308,000 on extra contractual activity and unplanned activity due to high cost procedures; and
- Overspend of £121,000 on Off Island Therapeutics due to high cost oncology and haematology drugs.

The Board was able to apply a contingency budget to offset these pressures. As part of the annual budget setting process, a contingency budget is established for general spend, extra-contractual referrals (patient referrals to mainland health boards which are above and beyond the expected amounts within the service level agreements with the boards) and prescribing. The standard budget in each of these areas will be set as the target for budget holders and will be used for the purposes of monitoring, however, if any overspends are identified during the year, the contingency budget will be used to offset these amounts.

Efficiency savings

The Board has achieved £2.139m of efficiency savings in 2014/15, meeting its target for the NHS Scotland Efficient Government efficiency savings target. The sources through which the Board has achieved these efficiencies are set out below:

Table 2: Efficiency savings 2014/15

Source	Savings £ million	% of total
Service Productivity	0.659	31%
Drugs & Prescribing	0.205	10%
Procurement	0.288	13%
Workforce	0.739	34%
Other sources	0.248	12%
Total reported	**2.139**	**100%**

90% of the Board's efficiency savings were made through recurring savings, with £223,000 (10%) identified from non-recurring sources.

Financial sustainability

In recent years NHS Boards in Scotland have faced significant challenges in delivering healthcare services amidst continued financial pressures. Audit Scotland's publication '*NHS in Scotland 2013/14*' recognises the difficulties caused by the focus on meeting annual targets and the extent to which this focus can hinder the longer term financial planning process. The overarching recommendation for NHS Boards is in relation to a strengthened approach to long term financial planning, considering in detail the resources required to implement service changes.

In light of this, financial sustainability has become a key matter for consideration by Boards and it is vital that consideration of longer term financial plans has taken place.

2015/16 financial plan

NHS Western Isles' Financial Plan for 2015/16 highlights the following key areas of income and expenditure, recurring and non-recurring:

Table 3: 2015/16 Financial Plan

NHS Western Isles	2015/16 Projected £ million
Recurring income	78.366
Recurring expenditure	80.840
Recurring savings	2.137
Underlying recurring (deficit)/surplus	-0.337
Non-recurring income	-1.093
Non-recurring expenditure	-1.069
Non-recurring savings	0.361
Non-recurring (deficit)/surplus	0.337
Financial (deficit)/surplus	0
Recurring deficit as percentage of recurring income	-0.430%

The financial plan shows recurring funding increasing from £74.374m to £78.366m and an increase in recurring expenditure from £76.874m to £80.840m.

The Board has not planned any underspends, with a break even position expected for the next three years. The plan assumes that net reliance on non-recurring funding sources to cover recurring expenditure in 2015/16 will be around £0.337m which is envisaged to continue in 2016/15 (£0.338m) and 2016/17 (£0.316m).

NHS Western Isles has identified that it is required to achieve efficiency savings of £2.498m in 2015/16 in order to achieve a break even position. The Scottish Government's expectation is that Boards will achieve 3% efficiency savings. The 3% target for NHS Western Isles is £1.92m and as such no further savings are required other than those which are necessary to achieve a break even position. The current position is that 77% of the £2.498m target has been identified, leaving £0.586m of currently unidentified savings. For each saving identified a risk must be assigned to it depending on the level of impact the efficiency scheme will have on protected groups. Of the identified savings the risk profile has been assessed as 34% high risk, 34% medium risk and 32% low risk schemes. Of the £0.887m identified as high risk, £0.586m relates to savings which have not yet been identified.

2016/17 and beyond

The Board has developed a three year financial plan to 2017/18 (submitted as part of the LDP) which forecasts a break even position in each year. In setting its three year plan, the Board considers the following to be the areas of greatest risk in future years:

Table 4: Future Risks

Risk	Impact
Mental Health strategy	Any double costs arising from the implementation of the Mental Health strategy could be significant and could persist for longer than planned, particularly when there is a reliance on staff turnover to effect changes in the establishment.
Adult Health and Social Care integration	There may be recurrent costs arising from the integration of Adult Health and Social Care which are not centrally funded.
Cash releasing efficiency savings	The largely recurrent cash releasing efficiency savings required to achieve break even in future years are significant and may not be achieved in full. The shortfall in each year could be £750,000 and the risk is rated high.

Risk	Impact
Highlands and Islands Travel Scheme	Although the transfer of the Highlands and Islands Travel Scheme to Boards' recurrent baselines brings opportunity for generating efficiencies through repatriation of services, there remains a risk that transport costs could rise and also a risk arising from local difficulties that services may have to revert to mainland providers.
Service development	The significant cost pressures described above may make further service development extremely difficult. The board has currently identified desirable service development of around £1.5m which it is currently assessing in terms of priority, but resource is unlikely to be available within this three year timeframe.

The Board's main capital commitment over the coming years will continue to be redevelopment of St Brendan's Hospital and Care Home in Barra. It is anticipated that the full business case for this scheme will be completed during 2015/16, with the construction phase taking place throughout 2016/17 and into 2017/18. Estimated capital costs for NHS Western Isles are expected to be £8.691m, with Cohmairle nan Eilean Siar committing an additional £2.4m. These costs are currently being reassessed as a result of a technical delay in the project.

Other capital projects include essential works at the Stornoway Health Centre, the modernisation of Mental Health services in the Western Isles and the upgrade of the Central Decontamination Unit (CDU) facilities at Western Isles Hospital.

Capital funding constraints in recent years mean that NHS Western Isles has deferred many routine schemes in order to use capital resources to fund essential projects. However, many of the previously deferred projects have now reached a critical stage and require urgent capital investment. Those presenting the highest risk will be addressed in 2015/16, however, this pressure in addition to the timing of the several large projects highlighted above means that the Capital Resource Limit will be under significant pressure in 2016/17 and 2017/18.

Financial planning and budgetary control

In order to support the balance between achieving targets in year and longer term financial planning it is vital that Boards' have in place a sound system of financial planning and budgetary control.

The annual budget setting process takes place in consultation with the different service areas based on indicative allocations from the Scottish Government. The Board has designated budget holders within the organisation who are responsible for the activities provided within that budget. Spend against budget is monitored on a monthly basis and monthly financial monitoring reports are prepared and are reported to the Board and Healthcare Governance and Audit Committee as standing items.

There is an appropriate financial planning and budgetary framework in place to support the Board's activities going forward.

Section 4. Governance and internal control

Governance structure

There has been no change to the Board's governance structure in the year, with the Board supported by the following standing committees:

- Healthcare Governance and Audit Committee;
- Staff Governance Committee;
- Remuneration Committee;
- Patient Focus and Public Involvement Committee, and
- Endowments Committee.

During the year the Board approved the permanent establishment of the Healthcare Governance and Audit Committee following a successful trial merger of the Clinical Governance Committee and the Risk Monitoring and Audit Committee which started in 2013/14. This merger was undertaken in response to the Francis report finding that there was a risk of oversight of issues by committees as they assumed another committee was addressing them.

The Board has also made a number of changes in the year to strengthen its internal control framework, including:

- An updated version of the Single Code of Corporate Governance for the board, which incorporates the Board's Standing Orders, Standing Financial Instructions, Scheme of Delegation and the constitution and terms of reference of the Board's standing committees;
- A complete review of the Code of Business Conduct.

At the start of the year the previously vacant position of Director of Public Health was filled and the Nursing Director left the organisation in February 2015. This post is currently being filled by an acting Nursing Director.

We consider that the governance arrangements in place are appropriate.

System of internal control

The Chief Executive Officer in conjunction with management and the Healthcare Governance and Audit Committee is responsible for developing and implementing systems of internal financial control and having in place proper arrangements to monitor their adequacy and effectiveness in practice.

We review these arrangements for the purposes of our audit of the financial statements and for our review of the annual governance statement and report to you any significant deficiencies in internal control that we find during our audit.

We have no significant matters to bring to your attention in relation to the system of internal control.

Based on our work performed we consider the systems of internal control to be appropriate.

Risk management

NHS Western Isles has a system in place for the identification, assessment, management and reduction of risk. The Board has a Risk Management Strategy in place which is accompanied by an action plan, monitored by the Healthcare Governance and Audit Committee.

The Board's risks are recorded on risk registers which are in place at Corporate, Single Operating Division and service level. The corporate risk register is a standing item on the agenda of the Healthcare Governance and Audit Committee and the Board.

Performance management

NHS Scotland has set a series of national HEAT targets and timescales which all Boards are expected to work towards. The HEAT targets are grouped into four priority areas:

- **H**ealth Improvement for the people of Scotland – improving life expectancy and health life expectancy
- **E**fficiency and Governance Improvements – continually improve the efficiency and effectiveness of the NHS
- **A**ccess to Services – recognising patients' need for quicker and easier use of the NHS services
- **T**reatment appropriate to Individuals - ensure patients receive high quality services that meet their needs

HEAT targets are monitored against Key Performance Measure trajectories that the Board has agreed with the Scottish Government Health and Social Care Directorate as part of its Local Delivery Plan. Performance against the HEAT targets is reported to the Board on a quarterly basis, with the reports setting out the targets, performance in that quarter and a performance review and improvement plan for any targets not meeting their planned trajectory.

Performance against key performance indicators as at May 2015 are summarised in the table below:

Table 5: HEAT targets

Target	Period	Actual	Status	Movement from prior year
Health Improvement				
Smoking Cessation Delivery of universal smoking cessation services to achieve a number of successful quits at 12 weeks post quit in the 60% most deprived within-island board SIMD areas by March 2015. Target: 93 successful quits at 12 weeks post-quit for people residing in the three most deprived local quintiles.	March 2015	29 successful quits	Off-target	↓
Early Access to Antenatal Services At least 80% of pregnant women in each SIMD quintile will have booked for antenatal care by the 12th week of gestation by March 2015. Target: 80.5% of pregnant women	March 2014	72.7%	Off-target	↑

Target	Period	Actual	Status	Movement from prior year
Efficiency				
Financial Performance NHS Boards to operate within their agreed revenue resource limit; operate within their capital resource limit; meet their cash requirement. Target: Achieve break-even position	March 2015	Achieved break-even position	On-target	⟷
Reduce Carbon Emissions Reduction in CO_2 emissions for oil, gas, butane and propane usage based on a national average year-on-year reduction of 3% each year to 2014-15 Target: CO_2 emissions of 1,470 for oil, gas, butane and propane.	December 2014	1,367	On-target	Not available
Reduce Energy Consumption To continue to reduce energy consumption based on a national average year-on-year energy efficiency target of 1% each year to 2014-15. Target: Energy consumption of 30,495.	December 2014	25,741	On-target	Not available
Access				
Faster access to specialist CaMHS Deliver 26 weeks from referral to treatment for specialist CaMHS services from March 2013, reducing to 18 weeks from December 2014. Target: 97% of patients for specialist CaMHS services seen within 18 weeks.	March 2015	100%	On-target	⟷
Faster access to Psychological Therapies Deliver 18 weeks referral to treatment for Psychological Therapies from December 2014. Target: 90% of patients for Psychological Therapies seen within 18 weeks.	March 2015	66.7%	Off-target	↓

Target	Period	Actual	Status	Movement from prior year
Treatment				
Dementia To deliver expected rates of dementia diagnosis using Eurocode prevalence model. Target: To maintain Western Isles Dementia QOF Register (50% of estimated number of people with dementia) – target 289.	March 2015	322	On-target	
MRSA/MSSA Bacterium To further reduce healthcare associated infections so that by 2014/15, staphylococcus aureus bacteraemia (including MRSA) cases are 0.24 or less per 1000 acute occupied bed days. Target: 0.24 or less per 1000 acute occupied bed days.	Year to March 2015	0.18	On-target	
C. Diff infections To further reduce healthcare associated infections so that by 2014/15, the rate of Clostridium Difficile in patients aged 15 and over is 0.32 cases or less per 1000 total occupied bed days. Target: 0.32 cases or less per 1000 total occupied bed days.	Year to March 2015	0.58	Off-target	
75+ Bed Days NHS Boards will achieve agreed reductions in emergency impatient day rates for people aged 75 and over between 2009/10 and 2014/15 through improved partnership working between the acute, primary and community care sectors. Target: 4,933 emergency inpatient bed days for patients aged 75+	November 2014	5,605	Off-target	Not available
Delayed discharge No people will wait more than 28 days to be discharged from hospital into a more appropriate care setting once treatment is complete from April 2013; followed by a 14 day maximum wait from April 2015. Target: 5 people	March 2015	6	Off-target	

Target	Period	Actual	Status	Movement from prior year
Detect Cancer Early NHS Scotland is to achieve a 25% increase in the proportion of people diagnosed and treated in the first stage of breast, colorectal and lung cancer by 2014/15 Target: 28% of breast, colorectal and lung cancer cases to be diagnosed at Stage 1 of the disease.	December 2013	24.4%	Off-target	Not available
IVF Treatment Waiting Times Eligible patients will commence IVF treatment within 12 months by 31 March 2015. The target will be based on the proportion of patients who were screened at an IVF centre within 12 months of the decision to treat. Target: 100%	December 2014	100%	On-target	Not available
Dementia: Post-Diagnostic Support All newly diagnosed with dementia will have a minimum of a year's worth post-diagnostic support co-ordinated by a link worker, including the building of a person-centred support plan by 2015/16.	March 2015	100%	On-target	Not available

Delayed Discharges

One area of public scrutiny and an area of significant cost pressure for the board is delayed discharges. From April 2013 onwards, no patient should wait more than 28 days to be discharged from hospital into a more appropriate care setting after being recognised as fit for discharge. This was reduced to a maximum of 14 days from April 2015. Table 6 below shows that in the past five quarters NHS Western Isles has failed to achieve the 28 day discharge target:

Table 6: Total number of delayed discharges (Source: ISD)

	Jan-14	Apr-14	Jul-14	Oct-14	Jan-15
Total Delays beyond 28 days (excluding Code 9s and delays between 1 and 3 days)	**7**	**6**	**4**	**9**	**14**

Weekly meetings are held to discuss delayed discharges and to monitor and manage actual and potential delayed discharges. Additionally, a report is presented to the Board on a quarterly basis to update Board members on the numbers of delayed discharges along with the associated risks and actions. Key actions include:

- Monitoring of delayed discharges by the Joint Planning Group (for Health and Social Care Integration); and
- Individual case reviews of delays implemented. Discharge Action Group to continue to review all delayed discharges and potential delays.

Internal Audit

We have reviewed the work of the Board's internal audit function and have used it to understand and evaluate the control environment of the Board and to focus our audit on particular areas of risk. Areas of activity during the year have included reviews into delayed discharges, estates and asset management, consultant contracts and a review into financial controls in relation to expenditure and bank and cash.

Based on audit work performed we consider the Internal Audit function to be appropriate for the needs of the Board.

Health and social care integration

The Public Bodies (Joint Working) (Scotland) Act 2014 was passed in April 2014 as part of the Scottish Government's agenda to drive improvement in the provision of health and social care services. The act details the integration models available to Health Boards and Local Authorities in developing their integration strategy as well as required documentation and timescales for delivery of integration schemes.

In August 2014 the Board approved the decision to deliver integrated health and social care services through an Integration Joint Board. A Joint Planning Group (JPG) was established to support integrated working and engagement between NHS Western Isles and the Comhairle nan Eilean Siar on leadership, strategic direction and management in relation to health and social care planning. The following four workstreams have been established in order to support the development of a Scheme of Integration: corporate governance; clinical and care governance; workforce, and performance management.

Following the agreement of an integration scheme, it was submitted jointly by the Board and the Council for approval by Scottish Ministers. The Integration Scheme was approved by the Scottish Government in June 2015 and will be laid before parliament to be established by Order of the Scottish Ministers. It is expected that the Joint Board will come into force in September 2015. Membership of the Joint Board has yet to be agreed by the Board and the Comhairle.

Other matters

Compensation and Confidentiality Agreements

During the year no exit packages were paid by the Board and as such, no confidentiality agreements were in place.

Medical workforce

Medical workforce shortages across the Health sector in Scotland are leading to an increased use of medical locums, having a significant impact on the costs associated with staffing certain specialties. During 2014/15 NHS Western Isles spent £1,290,932 on the use of medical locums within the following key specialties:

Table 9: Areas of medical locum spend

Specialty	2014/15 Spend £
Junior Doctors	4,512
Anaesthetics	17,772
General Medicine	498,337
General Surgery	469,790
Obstetrics and Gynaecology	76,342
Paediatrics	101,930
Radiology	122,299

Spending on medical locums has increased over the past five years by 37% as illustrated in Table 10:

Table 10: Medical Locum Spend over the past 5 years

	2010/11 £'000	2011/12 £'000	2012/13 £'000	2013/14 £'000	2014/15 £'000
Locum Spend (£000)	940	957	2,010	1,203	1,291

The spike in locum spend in 2012/13 was predominantly due to vacancies in general medicine and cover for Mental Health staff on long term sick leave.

In response to the increased reliance on medical locums the Board has undertaken the following key actions:

- Negotiations with agencies to reduce the flat hourly rate to cover on call shifts;
- Advertising for substantive consultant posts, fixed term consultant posts and bank consultant posts with varying degrees of success as the remote location of the islands, the on call rota and the autonomy of the job can be a barrier to recruitment. Recently the Board has been trying to recruit abroad; and
- The Board has been proactive in looking at projects that will help recruit medical staff and was the lead partner in the £3m EU Northern Periphery Programme Recruit and Retain Project which set out to find solutions for the difficulties in recruiting and retaining high quality professionals to work in the public sector of the remote rural areas of Northern Europe. A bid has been entered for further funding of the second phase of this project.

Section 5. Fraud

International Standards on Auditing (UK&I) state that we, as auditors, are responsible for obtaining reasonable assurance that the financial statements taken as a whole are free from material misstatement, whether caused by fraud or error. The respective responsibilities of auditors and management are summarised below:

Auditors' responsibility

Our objectives are:

- to identify and assess the risks of material misstatement of the financial statements due to fraud;
- to obtain sufficient appropriate audit evidence regarding the assessed risks of material misstatement due to fraud, through designing and implementing appropriate responses; and
- to respond appropriately to fraud or suspected fraud identified during the audit.

Management's responsibility

Management's responsibilities in relation to fraud are:

- to design and implement programmes and controls to prevent, deter and detect fraud;
- to ensure that the entity's culture and environment promote ethical behaviour; and
- to perform a risk assessment that specifically includes the risk of fraud addressing incentives and pressures, opportunities, and attitudes and rationalisation.

National Fraud Initiative (NFI)

The Board participates in the National Fraud Initiative (NFI). 87 recommended matches were identified for the 2014/15 year and management have investigated these and uploaded all results on to the national NFI system. In accordance with our responsibilities as your appointed auditor, we have completed the NFI questionnaire and noted the following key outcomes:

- There is clear ownership for collating NFI data and updating the NFI system via the Head of Finance and Procurement;
- There is sufficient reporting of the NFI process and outcome to the Healthcare Governance and Audit Committee; and
- The Board has not identified any fraudulent transactions to date from the investigation of matches.

Prevention and detection of fraud and corruption

The Director of Finance of the Board is also the designated Fraud Liaison Officer.

The Board has in place a Fraud Policy and a Counter Fraud action plan. This has included developing a counter fraud communication strategy, reviewing arrangements in place in relation to the prevention of bribery, raising awareness of fraud amongst new staff and raising awareness of fraud amongst primary care contractors. Fraud reports are routinely presented to the Healthcare Governance and Audit Committee. This includes progress against the Counter Fraud action plan as well as any national developments released by Counter Fraud Services.

Based on audit work performed we consider the controls in place to prevent and detect fraud or corruption to be suitable for the operations of the Board.

Section 6. Independence

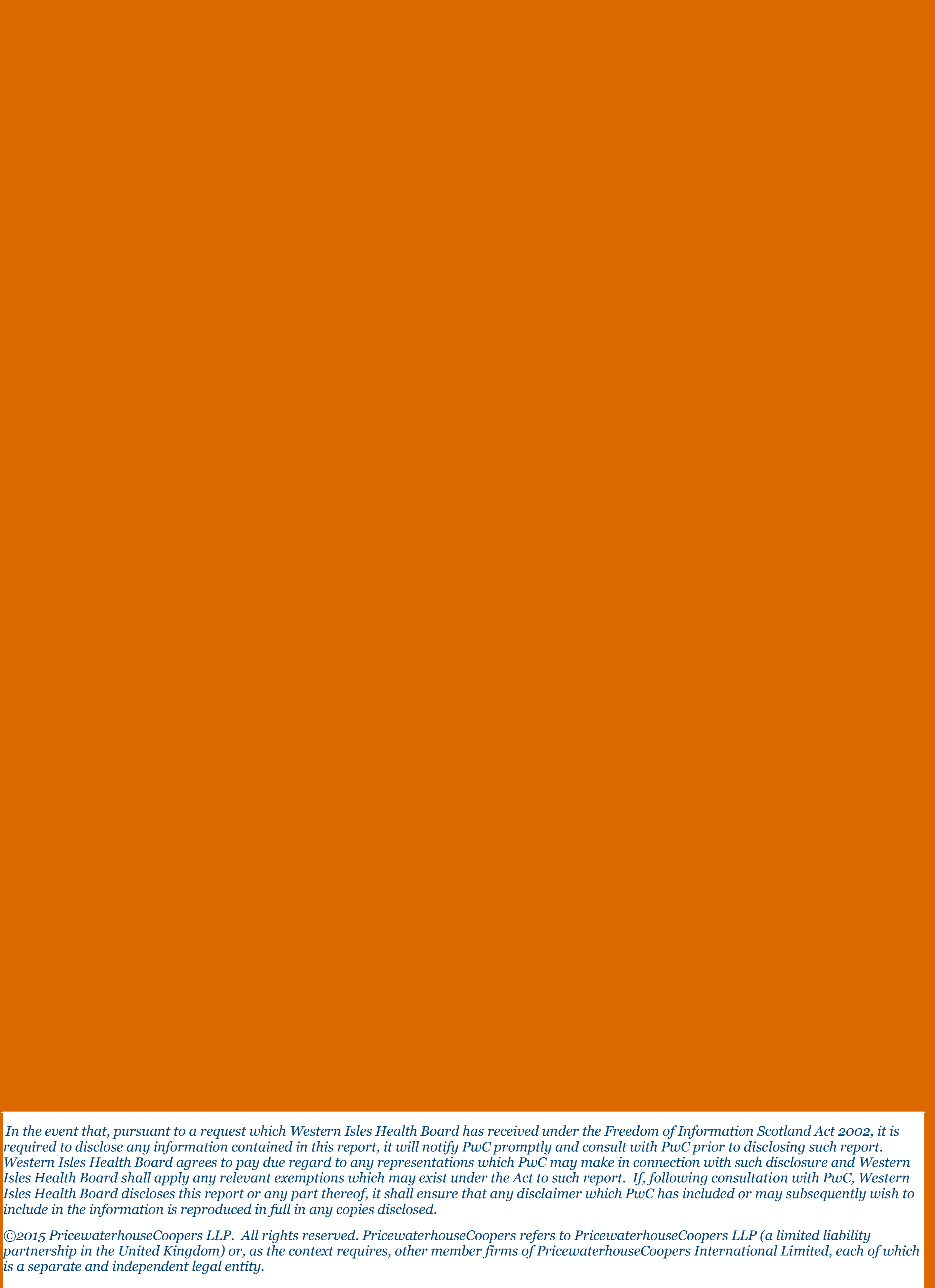
Independence and objectivity

We have made enquiries of all PricewaterhouseCoopers' teams providing services to you and of those responsible in the UK Firm for compliance matters.

There are no matters which we perceive may impact our independence and objectivity of the audit team.

Independence conclusion

At the date of this plan we confirm that in our professional judgement, we are independent accountants with respect to the Board, within the meaning of UK regulatory and professional requirements and that the objectivity of the audit team is not impaired.



In the event that, pursuant to a request which Western Isles Health Board has received under the Freedom of Information Scotland Act 2002, it is required to disclose any information contained in this report, it will notify PwC promptly and consult with PwC prior to disclosing such report. Western Isles Health Board agrees to pay due regard to any representations which PwC may make in connection with such disclosure and Western Isles Health Board shall apply any relevant exemptions which may exist under the Act to such report. If, following consultation with PwC, Western Isles Health Board discloses this report or any part thereof, it shall ensure that any disclaimer which PwC has included or may subsequently wish to include in the information is reproduced in full in any copies disclosed.

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