

# Argyll and Clyde Health Board

**Report on the 2005/6 Audit**



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# Executive Summary

## Introduction

In 2005/6 we looked at the key organisational risks around managing the dissolution and integration of NHS Argyll & Clyde, delivering safe services, achieving financial balance, managing the workforce and arrangements towards the achievement of Best Value and the Scottish Executive's efficient government initiative. We audited the financial statements and looked at aspects of performance management and governance. This report sets out our key findings.

## Dissolution & Integration

The Minister for Health & Community Care announced his decision to consult on the dissolution of NHS Argyll & Clyde in May 2005. Following a period of public consultation on the potential geographical boundaries of the new boards, NHS Argyll & Clyde was dissolved on 31 March 2006, and its assets, liabilities and the responsibility for delivering health services within its geographic boundaries were transferred to the successor boards, NHS Highland and NHS Greater Glasgow & Clyde. The decision to dissolve the Board represented a major risk to its ability to maintain the delivery of safe services during 2005/6.

Structures and processes were implemented to manage the dissolution and integration process in partnership with the inheriting boards. NHS Argyll & Clyde continued to function during the year and it maintained its committee and board structures throughout this period.

As a consequence of the dissolution announcement, NHS Argyll & Clyde consulted with the inheriting boards on major decisions prior to approval from its own board. It did not proceed with some significant plans, such as its clinical strategy and the planned development of its community health partnerships (CHPs). All of its plans will now be considered by the successor boards and taken forward as part of their own service strategies.

## Service Sustainability

As a result of the dissolution, NHS Argyll & Clyde did not proceed with its clinical strategy as originally planned. A decision on the acute element of the clinical strategy was deferred by the Board in November 2004, until the Kerr Report was published. No decisions were taken after its publication and NHS Argyll & Clyde continued to operate without a long term acute strategy during 2005/6.



The non-acute element of the clinical strategy received ministerial approval in May 2005, prior to the dissolution announcement. Detailed plans were developed during the year and were presented to the August 2005 board meeting for approval and further updates were presented in November and December 2005. However, these were not taken forward as the proposals were not aligned with the plans of the successor boards or accepted by the Board's local authority partners.

## Financial Position

We have given an unqualified opinion on the financial statements of Argyll & Clyde Health Board for 2005/6. We have, however, provided an explanatory paragraph in relation to the dissolution of the Board, the transfer of its responsibilities to the successor boards and the clearance of the cumulative excess.

The Board's financial performance in 2005/6 was as follows:

*Table 1  
2005/6 Financial Performance*

<b>Description</b>	<b>£ million</b>
Planned in-year operating deficit	(23.0)
Actual in-year operating deficit before additional RRL allocation	(22.2)
Cumulative deficit	(81.7)
Revenue Resource Limit	533.7
Year end additional RRL allocation from SEHD to clear cumulative deficit	82.3
Revised RRL	616.1
Net Resource Outturn	615.5
Revised cumulative surplus	0.6
Planned savings target	14.0
Actual savings achieved:	
Recurring	9.3
Non-recurring	5.1
Total	14.4

The financial recovery plan set challenging targets and these were met by the Board during 2005/6. At the start of the financial year, the Board identified that it had a potential in-year deficit of £37 million. Planned savings of £14 million were applied against this target to leave an in-year target deficit of £23 million. The Board achieved £14.4 million of savings, including £9.3 million on a recurring basis. Some savings were expected from the non-acute clinical strategy. However, as these plans were not implemented, this has



implications for the inheriting boards' future savings and clinical plans. A total of £14m savings were originally planned to come from this source over the period of the financial recovery plan.

The Board managed its financial position during the year, whilst accommodating cost pressures including additional costs of clinical and medical negligence claims and increased amounts payable for agency and locum staff as a result of difficulties in recruiting to some specialties. Additional costs attributable to the dissolution of the Board also arose during 2005/6. In addition, the expected receipt from the sale of the Hawkhead Hospital site was delayed until 2006/7 and the £10 million proceeds will now be received by NHS Greater Glasgow & Clyde.

NHS Argyll & Clyde had a recurring expenditure gap of £28.4 million; however it managed its financial position through the achievement of savings programmes and slippage in non-recurring funding. This difference between recurring income and expenditure is a risk to the successor boards' own financial positions. The majority of the recurring expenditure gap will transfer to NHS Greater Glasgow & Clyde. We are advised that discussions between the successor boards and the SEHD around transitional funding are ongoing. NHS Greater Glasgow & Clyde plans to implement its own financial recovery plan to restore financial balance to the Clyde area over a three year period.

When the Minister made his decision to dissolve NHS Argyll & Clyde, he also committed £80 million to clear its projected cumulative deficit at 31 March 2006. Discussions between the Board and the Scottish Executive Health Department (SEHD) at the year end resulted in a final allocation of £82.3 million in May 2006, greater than the cumulative deficit of £81.7 million in the financial statements received for audit. As we noted in previous audit reports, NHS Argyll & Clyde had no other plan to repay this amount.

## **Performance Management**

NHS Argyll & Clyde continued to perform well against the SEHD's waiting times targets during 2005/6. This successful performance was achieved against the backdrop of dissolution and the Board's financial problems. There was the potential that performance against targets could have fallen during the year.

Performance reporting arrangements also improved during the year through the introduction of quarterly performance reports to Board meetings. This served to address the point we made in our annual report last year which noted the absence of a systematic or structured manner of performance reporting to Board members.

Last year we reported that risk management arrangements were not sufficiently developed to provide a systematic approach for identifying, evaluating and responding to risks. The dissolution announcement slowed the progress that NHS Argyll & Clyde made in response to our report. In particular, divisional risk registers were not in place during 2005/6.



## Governance

In response to the dissolution announcement, senior management established interim management and governance arrangements. The divisional committee governance and management arrangements were replaced with a single management group and unified governance committee.

Structures were established to manage the dissolution and integration process, in partnership with the successor boards. A Dissolution & Integration Project Board (DIPB) comprising the chief executives of NHS Argyll & Clyde, NHS Greater Glasgow and NHS Highland and a representative from the SEHD met in June 2005 to set up a management and executive governance framework. It continued to meet throughout the year and took key decisions to direct the dissolution and integration process.

A project plan and risk log was used to identify key tasks and risks and allocate responsibility to individual officers to action. The plan focussed primarily on dissolution issues, with significant integration steps left to the successor boards.

NHS Argyll & Clyde responded positively to the dissolution announcement in respect of its staff governance responsibilities and considered a broader range of actions than were originally planned in its staff governance action plan.

**Audit Scotland**  
**June 2006**



# Introduction

1. This report summarises the findings from our 2005/6 audit of NHS Argyll and Clyde. The scope of the audit was set out in our Audit Risk Analysis & Plan, which was presented to the Audit Committee on 8 February 2006. This plan set out our views on the key business risks facing the Board and described the work we planned to carry out on financial statements, performance and governance.
2. We have issued a range of reports this year, and we briefly touch on the key issues we raised in this report. Each report set out our detailed findings and recommendations and the Board's agreed response. Appendix A of this report sets out the key risks highlighted in this report which have implications for the successor boards and the action planned by management to address them.
3. This is the final year of a five year audit appointment. We would like to take this opportunity to express our appreciation for the assistance and co-operation provided by officers and members of the Board during the course of our appointment. This report will be submitted to the Auditor General for Scotland and will be published on our website. [www.audit-scotland.gov.uk](http://www.audit-scotland.gov.uk)



# Organisational Risks

## Introduction

4. In our audit plan, we identified five main areas of risk for NHS Argyll & Clyde. We also described longer term planning issues which will impact on the successor boards. In this section, we describe the risks and our views on their current status. We also comment on longer term planning issues.

## Dissolution & Integration

5. In our audit plan, we commented on the risks that radical organisation change such as the dissolution of the Board would pose to its effectiveness during 2005/6. Our audit of NHS Argyll & Clyde was set in the wider context of the dissolution and focused on reviewing the robustness of the systems of internal control and financial management arrangements. Our finding from our review of the dissolution process are summarised at paragraphs 30 to 33.

## Delivering Safe Services

6. In our audit plan, we noted that that the implementation of the clinical strategy had been put on hold following the dissolution announcement and contingency arrangements were put in place to ensure that services continued to function. It had originally been agreed that plans to progress the acute element of the clinical strategy would be developed during 2005/6 following the publication of the Kerr report. However, the acute element on the clinical strategy was not progressed during 2005/6 and future decisions on the structure of services now rest with the successor boards.

### **Action Point 1**

7. Contingency plans designed to ensure the continuation of safe services were in operation during the year. The Board also voted in August 2005 to move some paediatric services, which it decided were no longer sustainable, from Inverclyde Royal Hospital to the Royal Alexandra Hospital. However, this decision was later reversed by the Minister for Health & Community Care who considered there was insufficient public consultation before reaching this decision.
8. NHS Argyll & Clyde did not take any major service decisions beyond this date, without consulting with the successor boards. Risks remained around NHS Argyll & Clyde's ability to deliver safe, sustainable services in an environment of changing clinical demands.



9. In May 2005, prior to the dissolution announcement, the Minister for Health & Community Care gave approval to develop detailed plans to support the implementation of the non-acute element of NHS Argyll & Clyde's clinical strategy. Plans designed to implement the strategy were progressed during the year and taken to the August 2005 Board meeting for approval. Further updates were presented to the November and December board meetings. However, the Board voted not to approve these plans as they were not aligned with the financial recovery plan and would not have produced the required level of savings. They were also not supported by the successor boards or by their local authority partners. Subsequently, and in consultation with the successor boards, NHS Argyll & Clyde decided not to proceed with implementing the non-acute clinical strategy before dissolution.

#### **Action Point 2**

## **Achieving Financial Balance**

10. In our audit plan, we commented that there were risks that 2005/6 savings, which supported larger savings in future years, would not be achieved unless the clinical strategy proceeded as planned. We also commented on the need for robust financial management during 2005/6 to manage the risk of national initiatives exceeding estimated costs in the financial planning period.
11. At the end of 2005/6, expenditure exceeded income by £22.3 million, compared to a planned in-year deficit of £22.5 million. Combined with the deficits incurred in previous years, NHS Argyll & Clyde had a final cumulative excess of £81.7 million at the year end. However, a final RRL allocation of £82.3 million was notified by the SEHD in May 2006. This cleared the cumulative deficit and left a surplus of £0.6m at the point of dissolution.
12. The NHS Argyll & Clyde financial recovery plan indicated that an in-year break-even position would have been achieved at the end of 2007/8. However, this was reliant upon the forecasts from the implementation of the Board's clinical strategy and its ability to achieve significant further savings from the implementation of service redesign proposals. Progress on implementation of the clinical strategy would impact on achievement of cost savings within the financial recovery plan.
13. A methodology to split the NHS Argyll & Clyde expenditure plans between the successor boards was agreed during the year. The successor boards are inheriting an underlying mismatch in income and expenditure and inheriting an underlying deficit of £28.4 million in total.

## **Managing the Workforce**

14. We reported in previous years that NHS Argyll & Clyde did not have wholly adequate systems in place to provide the necessary workforce information for strategic management and service planning. The



Board implemented the Empower workforce information system during the year and this improved the quality of workforce information used to support planning and decision making.

15. As part of the dissolution and integration process, a Human Resources sub-group of the Dissolution and Integration Project Team (DIPT) was established to manage HR related dissolution matters. It principally developed arrangements for the transfer of staff from NHS Argyll & Clyde to the successor boards on 31 March 2006.

## **Best Value and Efficient Government**

16. In our audit plan, we identified that Accountable Officers have a duty to ensure that arrangements are in place to secure Best Value. There is no statutory duty of Best Value in the wider public sector. Instead, the Scottish Executive issued draft secondary guidance in August 2003, on the duty of accountable officers to ensure arrangements are in place to secure Best Value. NHS Argyll & Clyde had not carried out a review of its services against the requirements of Best Value before its dissolution. Aspects of its procedures and protocols contained elements attributable to Best Value, but as a full review had not been implemented, the Board was therefore unable to demonstrate fully that it was adhering to Best Value principles in the delivery of its services and responsibilities.
17. We carried out an overview of NHS Argyll & Clyde's management arrangements in relation to the requirements of the Scottish Executive's efficient government initiative. All boards are required: to reflect the requirements of efficient government in a programme for delivering efficiency savings; to monitor the effectiveness of change programmes; to take corrective action where necessary and ensure effective leadership throughout the process.
18. Efficiency savings were a key part of the Board's financial strategy for a number of years as part of the implementation of its financial recovery plan. Savings of £14.4 million were achieved during 2005/6, £10.4 million of which are attributable to the efficient government initiative.



# Financial Statements

## Our Responsibilities

19. We audit the financial statements 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 period in question;
- whether they were prepared properly in accordance with relevant legislation, applicable accounting standards and other reporting requirements; and
- the regularity of the expenditure and receipts.

20. We also review the Statement on Internal Control by:

- considering the adequacy of the process put in place by the Chief Executive as Accountable Officer to obtain assurances on systems of internal control; and
- assessing whether disclosures in the Statement are consistent with our knowledge of the Board.

## Overall Conclusion

21. We have given an unqualified opinion on the financial statements of Argyll and Clyde Health Board for 2005/6. We have, however, provided an explanatory paragraph to our opinion on the Board's financial position. This draws attention to the fact that responsibility for services was transferred to Highland Health Board and Greater Glasgow Health Board on the 1 April 2006, and the £81.7 million accumulated excess of Argyll and Clyde Health Board was cleared, through the enhanced provision within the final Revenue Resource Limit from the Scottish Executive Health Department.



## The Board's Financial Position

22. The Board is required to work within the resource limits and cash requirement set by the Scottish Executive Health Department. NHS Argyll and Clyde's performance against these targets is shown in Table 2 below.

*Table 2  
2005/6 Financial Targets Performance £ million*

<b>Financial Target</b>	<b>Target</b>	<b>Actual</b>	<b>Variance</b>
Revenue Resource Limit	616.1	615.5	0.6
Capital Resource Limit	16.0	14.5	1.5
Cash Requirement	592.3	592.3	-

23. The financial recovery plan set challenging targets for the Board and these were met during 2005/6. At the start of the financial year, NHS Argyll & Clyde identified that it had a potential in-year operating deficit of £37 million. Planned savings of £14 million were applied against this target to leave an in-year target deficit of £23 million. The in-year deficit reported in the unaudited annual accounts was £22.2 million. A final additional RRL allocation of £82.3 million was received from the SEHD in May 2006 to clear the cumulative deficit and this resulted in a surplus of £0.6 million. See table 3 below for further analysis.

*Table 3  
2005/6 Comparison of financial plan and actual position £ million*

<b>Description</b>	<b>£ Million</b>
Planned 2005/6 deficit —financial recovery plan	(37.0)
Savings achieved	14.4
Additional unplanned clinical negligence costs	(1.0)
Year end adjustments	1.4
Cumulative deficit from previous years	(59.5)
Additional RRL allocation	82.3
<b>Reported 2005/6 surplus</b>	<b>0.6</b>



24. NHS Argyll & Clyde achieved £14.4 million of savings during 2005/6, with £9.3 million on a recurring basis. However, savings were not made from the areas originally planned and this has implications for the successor boards' financial recovery plans. This represents continued progress and demonstrates that the Board was able to manage its financial position to meet its financial plan despite a number of cost pressures which arose throughout the year. For example the costs associated with clinical negligence claims and the costs arising from the use of agency and locum staff were higher than expected.

Table 4  
Funding Position 2005/2006

Description	£ Million	£ Million
Recurring Income	644.7	
Recurring Expenditure	(673.1)	
<b>Estimated underlying recurring gap</b>		<b>(28.4)</b>

25. NHS Argyll & Clyde's recurring income and expenditure amounts were £644.7 million and £673.1 million, leaving a recurring funding gap in year of around £28.4 million. The Board managed this position through corporate savings programmes and slippage on developments.

26. The underlying deficit of approximately £28.4 million has now been passed to the successor boards. It will be the responsibility of the successor boards to manage this position and we understand that discussions between the SEHD and the successor boards are ongoing around bridging finance. NHS Greater Glasgow & Clyde have also agreed to produce a new financial recovery plan by December 2006.

## The Issues Arising from the Audit

27. We reported two main issues to the Audit Committee on 20 June 2006:

**Termination Payments:** As part of our financial statements audit testing, we have reviewed all disclosures for redundancy and early retirements to 31 March 2006, including that of the Chief Executive. We are satisfied that they are consistent with supporting documentation and were disclosed in accordance with the requirements of the NHS Accounts Manual.

**Resolution:** For noting only.

**Sale of Accord Hospice:** The Accord Hospice is a third party organisation which provides long term health care services to patients. Its single story building is situated on the Hawkhead Hospital site, which NHS Argyll & Clyde has agreed to sell to developers, the sale of which will be completed during



2006/7. Accord had rented its property from NHS Argyll & Clyde for a number of years until it reached an agreement to purchase its land and building from the board during 2005/6 for £250,000. A gain on disposal of £46,000 was disclosed in the financial statements, as it had a net book value (NBV) of £204,000. The sale was completed on 31 March 2006 and the proceeds received on 3 April 2006.

As part of the negotiation to sell the Accord and also to facilitate the sale of the Hawkhead site, NHS Argyll & Clyde is required to carry out enabling works so that the Accord Hospice will be self sufficient, as it currently receives its utility services, such as heating and lighting from the main hospital site. The financial statements included a creditor for £170,000 in respect of these works along with a £100,000 creditor for upgrading the Accord building to facilitate the integration of the palliative team with local health services. Both amounts were initially classified as capital grants within the Operating Cost Statement.

We asked the Board to confirm the treatment of the £100,000 as a capital grant in 2005/6. In addition we asked the Board to consider the appropriateness of the accrual of the enabling works, as these had not yet taken place, were more related to the Hawkhead sale due in 2006/7 and did not appear to fully meet the requirements for classification as a capital grant.

**Resolution:** The Board confirmed the treatment of the £100,000 capital grant and removed the £170,000 creditor for enabling works -this cost would be shown in 2006/7.

## Statement on Internal Control

28. The Statement on Internal Control provided by the NHS Greater Glasgow & Clyde Accountable Officer reflected the main findings from both external and internal audit work. The Statement refers to areas of internal control that need to be strengthened, including:

- Risk management arrangements are still developing. We reported in 2004/5 that plans to develop divisional risk registers had stalled following the dissolution announcement. No further progress was made during 2005/6. The responsibility to develop the CHP risk registers will now rest with the successor boards;
- Following the Minister's decision to dissolve NHS Argyll & Clyde on the 31 March 2006, it maintained its board and committee structures throughout the year. However the Board was unable to implement a number of policies and decisions, including its clinical strategy. For all major decisions it consulted the successor boards, NHS Greater Glasgow and NHS Highland;
- A number of key input and validation controls within the payroll system were not fully in place during the year and this reduced the reliability of the information produced from the system. There was also an absence of output controls, including regular exception reporting and review;
- Some concerns exist in respect of the processes used for the physical verification of assets;



- NHS Argyll did not have a fully tested business continuity plan in place during 2005/6. Service delivery was at risk in the event of an IT systems failure; and
- A number of key posts in the Procurement function remained vacant for part of the financial year. Therefore there was a risk that the proper managerial control and strategic direction was not exercised throughout the year within this function.



# Performance Management

## Introduction

29. This section covers our assessment of the way in which NHS Argyll & Clyde secures value for money in the use of its resources. This year we focussed on four main areas:

- Dissolution of NHS Argyll & Clyde;
- Performance management;
- Efficient Government; and
- Best Value.

## Dissolution of NHS Argyll & Clyde

30. We identified in our audit plan that radical organisational change, posed a significant threat to the Board's ability to operate effectively. We therefore reviewed the impact the dissolution announcement had on NHS Argyll & Clyde's ability to deliver services, maintain appropriate governance arrangements and operate effectively during 2005/6. In carrying out this review, we considered the impact of dissolution on NHS Argyll & Clyde's service plans, particularly its proposed clinical strategy and the overall effectiveness of its decision making processes during the year.

31. We concluded that NHS Argyll & Clyde and the successor boards worked in partnership to manage the dissolution process. The Dissolution and Integration Project Board (DIPB) comprising the Chief Executives of NHS Argyll & Clyde, NHS Greater Glasgow and NHS Highland and a representative from the SEHD was established to oversee and take key decisions to direct the dissolution and integration process. The DIPB also agreed to appoint a Transition Project Director to manage the process. This was a positive step which provided focus to the dissolution and integration and allowed existing NHS Argyll & Clyde staff, who had been involved in project management, to concentrate their efforts on operational responsibilities.

32. A DIPT, with membership from the three boards was also established to develop and implement a detailed project plan of key steps needed to bring about an effective dissolution and integration. The project plan was supported by a risk log which assigned actions and responsibilities to individual members of staff.



33. Although there was no non-executive membership of the DIPB or DIPT, the three board Chairs and Chief Executives met with the Chief Executive of the NHS in Scotland after each meeting of the NHS Chairs to review progress. Progress reports were also given to the NHS Argyll & Clyde Board on a monthly basis, but these tended to be verbal updates. Given the scale, significance and extent of the risks arising from the dissolution, a more formalised reporting of progress to the NHS Argyll & Clyde Board would have been appropriate.
34. NHS Argyll & Clyde did not implement Community Health Partnerships (CHPs) as planned during 2005/6. The SEHD did not approve the schemes of establishment for the five proposed CHPs prior to the dissolution announcement and there was limited progress in developing these during the year. The development and implementation of CHPs will now be taken forward by the successor boards.

### **Action Point 3**

## **Performance Management**

35. We reported in our 2004/5 Annual Report that NHS Argyll & Clyde's performance management arrangements were developing and had made progress against prior years. Further positive steps were taken during 2005/6, in particular the quarterly performance report to the board allowed members to track performance from one period to the next. The report highlighted success for the local health system in the achievement of waiting times targets for inpatient, day case and outpatients, as well as progress towards financial recovery and savings targets. It also drew attention to slippage against the targets for the reduction in delayed discharges.
36. The SEHD has moved to align NHS boards' performance management arrangement more closely with ministerial objectives. At the request of the SEHD, NHS Argyll & Clyde completed a Local Delivery Plan for 2005/6 and the information in this document will be of use to the successor boards.

## **Best Value**

37. There is no statutory duty of Best Value in the wider public sector. Instead, the SEHD issued draft secondary guidance in August 2003, on the duty of accountable officers to ensure arrangements are in place to secure Best Value. In May 2005, Ministers decided that they would not bring forward legislation which extends Best Value in the wider public sector. However, Ministers do wish to encourage and embed the principles of Best Value across the wider public sector, and the Best Value and Performance Team within the Scottish Executive were tasked with taking this forward. Revised guidance was issued in April 2006 and included in the Scottish Public Finance Manual.



38. We discussed the baseline with the Director of Finance, but agreed that there was little merit in going forward with a full review at this stage. NHS Argyll & Clyde's plans contained elements expected of a Best Value organisation, but it had not yet carried out its own detailed review against the requirements. A preliminary commentary on the results of the audit work will be addressed to clients to help inform discussions on how Best Value is developed in the NHS, during 2006.

#### **Action Point 4**

## **Efficient Government Initiative**

39. The Efficient Government initiative is a five year programme with the aim of attacking 'waste, bureaucracy and duplication in Scotland's public sector'. The primary objective is to deliver the same services with less money or to enable frontline services to deliver more or better services with the same money. The Efficient Government Plan sets targets to achieve £745 million (rising to £900 million) of cash-releasing savings, and £300 million (rising to £600 million) of time-releasing savings, by 2007-08. The NHS in Scotland is expected to contribute £166 million of cash releasing savings and £173 million of time releasing savings per year.
40. NHS Argyll & Clyde had a cost reduction programme in place since April 2004. This continued during 2005/6 with the identification of a further £14 million of savings. Progress against savings and the wider financial recovery plan were reported to the finance committee and the Board on a monthly basis. Other aspects of the efficient government initiative, such as asset management and managing absence were not as well developed and no savings were planned in these areas. A detailed position statement of all public sector organisations in Scotland is being produced by Audit Scotland and will be issued shortly. This information will also be of use to the successor boards.

## **National Studies**

41. In 2005/6, Audit Scotland carried out three national studies:
- Staff Governance review of previous year's action plan. Our findings are reported in paragraph 57 of the section on governance;
  - Tackling Waiting Times in the NHS in Scotland (reported to the Scottish Parliament in February 2006); and
  - Implementing the NHS Consultant Contract in Scotland (reported to the Scottish Parliament in March 2006).



## **Tackling Waiting Times in the NHS in Scotland**

42. This national study reviewed the performance of the NHS in Scotland against current waiting times targets for elective healthcare. It evaluated whether the current approach produces value for money and assessed whether current strategies are likely to achieve sustained reductions in waiting times.
43. The report concluded that significant progress had been made towards meeting waiting times targets, but that the total number of people waiting for inpatient and day case treatment has changed little in the last two years. It recommended that more efficient use be made of the Golden Jubilee National Hospital.
44. The report highlighted that patients being treated at NHS Argyll & Clyde hospitals had the highest average length of stay in Scotland. The duration spent in hospital for treatment is a measure of efficiency and this suggests that NHS Argyll & Clyde has the potential to reduce this time.

## **Implementing the NHS Consultant Contract in Scotland**

45. This report concluded that there were no clear benefits from the £235 million cost arising from the implementation of the consultant contract. It also highlighted that the new contract offers an opportunity to focus the work of consultants on priority areas, and improve patient care. However, it is not yet being used to its full potential and there is limited evidence of benefits to date. The report also noted that the consultant contract had contributed to cost pressures for boards as the national costing model used by the SEHD contained inaccuracies and it underestimated the financial cost by £171 million, on a national basis, for the first three years.



# Governance

## Introduction

46. This section sets out our main findings arising from our review of NHS Argyll & Clyde's corporate governance as it relates to:

- clinical governance;
- corporate governance; and
- staff governance.

## Clinical Governance

47. Over the past three years, we reported that the single largest risk factor which faced NHS Argyll & Clyde was the sustainability of safe, effective and appropriate clinical services, at the same time as addressing the serious financial position. The clinical strategy 'Shaping the Future' was designed to address this risk. We also noted in our 2004/5 Annual Report that following the dissolution announcement, it was essential that all decisions were aligned to the service development plans of the successor boards.

48. Ministerial approval to develop plans for the non-acute element of the clinical strategy was given in May 2005 and these were presented to the August 2005 Board meeting. However, the Board decided not to approve these plans as they were not sufficiently aligned with the financial recovery plan and would not have produced the expected level of savings. The financial recovery plan had projected that the implementation of the non-acute clinical strategy would contribute significantly to the achievement of £14 million of savings until 2007/8. However, achievement of savings on this scale will require the successor Boards to review existing proposals and identify areas where significant savings can be achieved from redesign of services.

**Action Point 2**

## Corporate Governance

49. Our work on corporate governance focused on our Code of Audit Practice responsibilities as they relate to systems of internal control; prevention and detection of fraud and irregularity; standards of conduct and the Board's financial position. We have made comment on the financial position at paragraphs 22 to 26.



50. We relied on the work of Internal Audit to give us assurance in these areas and we looked at two further specific areas of risk to see what governance arrangements were in place to manage them:

- IM&T Business Continuity & Planning; and
- Agenda for Change.

## **IM&T Business Continuity & Planning**

51. Effective business continuity planning (BCP) helps to reduce an organisation's business risk arising from unexpected disruptions of critical functions. At a time of major change, robust arrangements that ensure the continuity of service provision are critical. The dissolution introduced an added complexity in developing and operating effective business continuity planning arrangements, during 2005/6. Service delivery prior to and following the dissolution needs to be supported by high quality and effective information management & technology (IM&T) arrangements, including business continuity and disaster recovery procedures.

52. We concluded that NHS Argyll & Clyde's business continuity arrangements during 2005/6 did not support the effective delivery of service objectives. We noted that a disaster recovery strategy and detailed plan had not yet been put in place for the Board area. Data back up policies and procedures were not documented and staff have to complete required actions in their absence.

### **Action Point 5**

## **Agenda for Change**

53. We monitored developments in the implementation of the Agenda for Change process during 2005/6. The steering group met monthly and reported progress regularly to the Staff Governance Committee. The target date for implementation of Agenda for Change, through the completion of all assimilation and payment of arrears has been revised to 31 December 2006. However a number of local and national factors will have an impact on the achievement of this date, notably approximately 12% of former NHS Argyll & Clyde staff are now going through the job evaluation process. This is used when their job plans do not match the Agenda for Change profiles and could slow down the final assimilation process if appeals are initiated.

## **Staff Governance**

54. NHS Argyll & Clyde completed a self assessment audit and a staff survey to assess their effectiveness in staff governance. The self-assessment process was carried out in partnership with significant staff involvement. The resulting action plan was approved by the Partnership Forum and Management Team, and so had agreement and support across the organisation. This work is part of



an ongoing NHS Scotland initiative designed to recognise the value and importance of staff in service delivery and generally improve staff relations in the NHS.

55. This year we identified and assessed the risks associated with Staff Governance as part of the audit planning process and we reviewed the evidence that the previous year's action plan is being delivered.
  
56. We concluded that NHS Argyll & Clyde had made good progress in achieving actions agreed last year. We found that of 25 actions in last year's action plan, ten (40%) were fully implemented and nine (36%) are partially complete. Progress against six actions (24%), all of which were previously identified as medium priorities, had not progressed as planned, due to either a lack of management capacity or available resources. These included, the planned introduction of a workplace briefing system, a programme of partnership development and awareness training, the introduction of exit interviews for leavers and a planned review of Dignity at Work and Work-Life Balance policies. Incomplete actions will now pass to the successor boards for their consideration.



# Looking Forward

57. NHS Greater Glasgow & Clyde and NHS Highland face significant challenges in 2006/7 which include:

- Sustaining clinical services within the former NHS Argyll & Clyde area. The acute services section of the clinical strategy had not been agreed and the non-acute strategy was put on hold. Successor boards will now need to implement their own plans.
- The financial recovery plan may not be achievable. The NHS Argyll & Clyde financial recovery plan includes the need to achieve £14 million of savings from the non-acute clinical strategy until 2007/8. The successor boards will need to develop their own cost savings plans and we understand that proposals are being developed to return the former NHS Argyll & Clyde area to financial balance by the end of 2008/9. Transitional funding from the SEHD is being discussed with the successor boards to help facilitate this process.
- Community Health Partnerships were not developed as planned by NHS Argyll & Clyde, as their schemes of establishment were rejected. The successor boards in partnership with the local authorities will need to develop these in the former Argyll & Clyde area.



# Appendix A: Action Plan

## Key Risk Areas and Planned Management Action

Action Point	Refer Para. No	Risk Identified	Planned Action	Responsible Officer	Target Date
1	6	NHS Argyll & Clyde had no acute service strategy during 2005/6 and had not taken forward plans to address the requirements of Delivering for Health.	Strategy currently being reviewed.	Director of Acute Services Strategy, Implementation and Planning	September 2006
2	9	There is a risk that expected savings are not achievable and this jeopardises the success of the financial recovery plan.	Clyde Cost Savings Plan Programme now being developed.	Director of Finance Transition Project Director	December 2006
3	34	CHP were not implemented by NHS Argyll & Clyde. There is a risk that in their absence, the population of Argyll & Clyde will not fully benefit from the development and improvement of community health services.	CHPs have been established for Renfrewshire, East Renfrewshire & West Dunbartonshire. Inverclyde CHP will be established during 2006/07.	N/A  Chief Executive	Complete  March 2007
4	38	Draft guidance on Best Value was not implemented by NHS Argyll & Clyde and there was limited development of a local framework. There is a risk that the successor boards will not be able to demonstrate Best Value.	Will be developed in tandem with arrangements across NHS GG&C.	Director of Finance	Ongoing
5	52	NHS Argyll & Clyde did not have a disaster recovery strategy. There is a risk that required actions would not be completed in the event of a service failure.	Will be developed in tandem with arrangements across NHS GG&C.	Director of IT & Health Information	Ongoing