Highland Health Board

ANNUAL REPORT and ACCOUNTS

for

THE YEAR ENDED 31 MARCH 2022

Highland Health Board

INDEX **Page**

ANNUAL REPORT AND ACCOUNTS FOR YEAR ENDED 31 MARCH 2022

THE PERFORMANCE REPORT

1. Overview

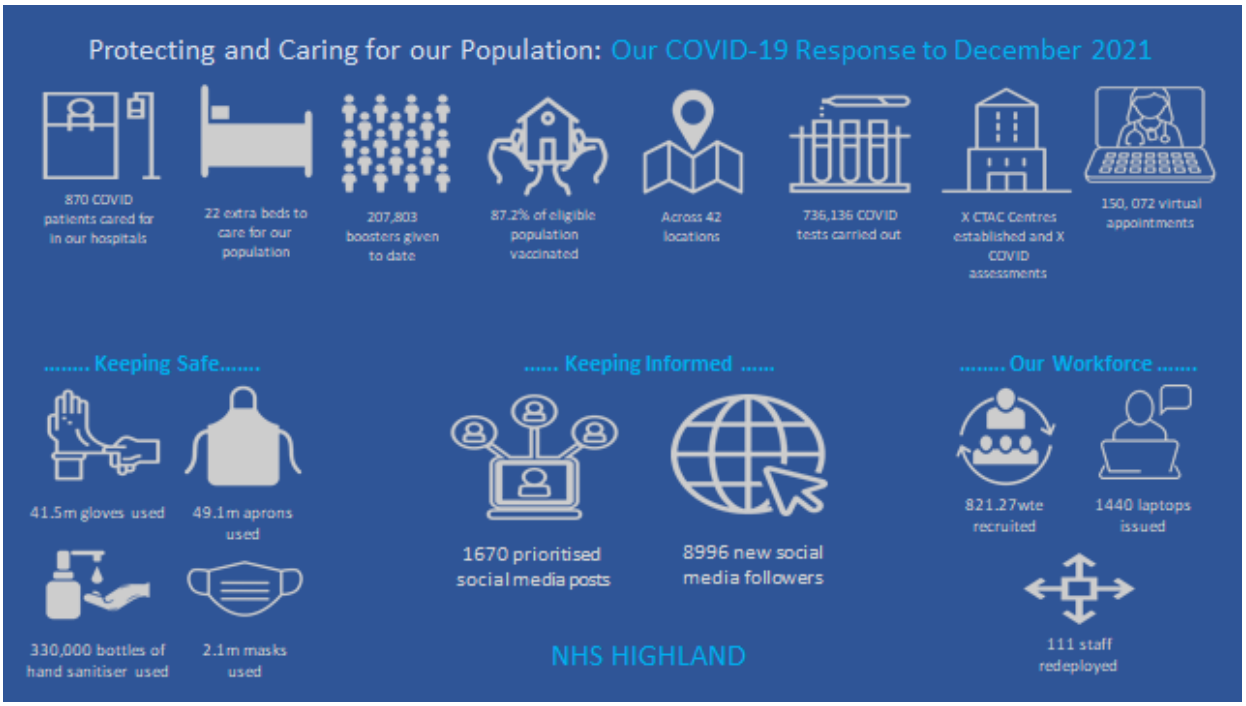
This overview summarises the key issues faced by NHS Highland in 2021/22, provides a broad description of the Board and its governance, looks at performance in the year towards the achievement of operational targets and looks ahead to the priorities to be addressed in 2022/23.

1.1 Chief Executive Statement

By the end of 2020-21, we knew that tackling the COVID-19 pandemic would be a marathon, and not a sprint. We were already veterans of adapting pathways, services and work styles to manage not only the direct impact of COVID on our population, but also the indirect effects such as loneliness and isolation, poor mental health, and the necessary reduction of some services. Now, another year later, we see both impacts compounded. While the severity of subsequent waves of COVID have thankfully been less acute, new strains have been more infectious, causing even greater disruption to our already fatigued workforce across both health and social care.

Our remote geography protected us to some extent earlier in pandemic, but those lower levels of infection earlier on may have left our population susceptible to higher infection rates in subsequent waves, due to lower natural immunity. Approaching the end of 2022, we have an unprecedented number of patients in hospital with COVID, often with other acute health needs to be attended to, as well as care homes closed to new admissions due to staff or residents testing positive.

The situation would be more serious still were it not for the success of our vaccination programme. Working alongside GPs, we delivered one of the highest take-ups in Scotland for first, second and booster vaccinations. The logistical challenge of making clinics accessible to hundreds of thousands of people across 12,500 square miles and 36 populated islands cannot be overestimated, and our learning from this will inform the future vaccination transformation programme.



That we have continued to be able to care for people, at home, in care homes, in GP surgeries, community settings and in acute and community hospitals, is down to the dedication and exceptional hard work of our staff. I cannot thank them enough for the professionalism and commitment they have shown.

It is tempting to describe these colleagues as ‘tireless’, but that would be incorrect.

In common with other boards, we face shortages of qualified staff – nurses, in particular. Unlike other boards, we also provide adult social care, and this workforce can be difficult to recruit and retain in the face of competition from hospitality and other industries. It will come as no surprise that a key priority for NHS Highland in 2022-23 will be recruitment, as we explore all avenues to grow our workforce.

We are all tired, exhausted even, and it is the job of senior leaders to find ways to ensure that constant pressure does not become the new normal. This task of reconfiguring and rethinking the way we work must go on, amidst the everyday delivery of care. It sits alongside our ongoing cultural transformation programme, encouraging people to speak up, share their ideas, and make their views known.

This programme includes Leadership and Management Development; provision to hold team conversations about collegiate working; the review of people processes; and the promotion of a range of supports for colleagues, from our Employee Assistance Programme to the Guardian Service, and national Whistleblowing Standards.

Looking forward, Civility Saves Lives and Promoting Professionalism in the workplace is a key priority for us in 2022-23. This will combine our colleague culture activity with ensuring our patients and service users have the best possible experience in a safe and respectful environment. We also want to be much clearer about individual objectives, ensuring everyone working at NHS Highland has the chance to have a meaningful discussion about their role, aims and development.

This applies as much to the communities we serve as to our internal teams, and this year we have been forging new relationships with a different approach to developing our five year strategy, ‘Together We Care’. This was our largest ever engagement exercise, reaching out to communities, patients, carers, service users, representative groups and, of course, our colleagues. Instead of presenting a narrow choice of options for action, we wanted to engage authentically, giving people the chance to meaningfully shape our priorities. And so, while we grouped topics into broad categories, we were led by local people in terms of how health and care should look in five years’ time, and how we could work together to make that happen.

Engagement was curtailed somewhat by the omicron wave of COVID-19, which led to some planned events having to be cancelled or moved online. Nevertheless, we are delighted to have reached over 500 community and stakeholder groups, holding face to face sessions in 12 locations across the area, as well as Highland-wide virtual sessions, and gathering over 1,200 responses.

We entered 2021-22 with a plan for a balanced budget, and have continued to deliver savings and efficiencies, as well as service improvements, while dealing with the ongoing effects of the pandemic. We welcome additional funding granted for the vaccination programme and other aspects of care impacted by Covid. In common with other boards, however, we continue to face unprecedented financial pressures, including fuel price and wage increases. We cannot rely on short-term, non-recurrent savings to solve this, but will need to effect significant changes to how we deliver services in the future.

Case study: prescribing

In 21/22 the prescribing workstream, as part of our cost improvement programme, was set a target to make £1m of savings. We exceeded this target by 20%. This included

improving the quality and quantity of prescribing as well as close monitoring of national procurement for price reductions and rebates.

One example of this is the transfer of HIV Drugs to Homecare. Homecare is a service where repeat prescriptions are mailed out to an address of people's choosing. Not only can Homecare be cheaper for NHS Highland in terms of the cost of supplying drugs, saving £42,000 in the last year, but it is also much more convenient for our patients. It means that people do not have to come to hospital to see a consultant to get a repeat prescription.

Much of our focus in secondary care has been trying to implement changes as soon as possible to ensure we obtain maximum benefit with price reductions, without impacting on safety or quality of care.

For 22/23 we will focus on quality with work starting in primary care using the National Therapeutic Indicators and understanding (and reducing where possible) variation across Boards as well as within our own Board.

This year saw us continue to build our senior team, with a number of new appointments helping to support the work of the Executive team.

Fiona Davies, who had been covering the position of Chief Officer of Argyll and Bute HSCP on an interim basis, was successful in being appointed to the permanent role.

Paul Davidson retired from his post as Deputy Medical Director for Primary Care, and I would like to thank him for his work in this role, and throughout his career. The position has been filled by on an interim basis by Denise Macfarlane. We also welcomed Constantinos Yiangou and Robert Cargill as Deputy Medical Directors for Acute. Mike Hayward joined us as Deputy Chief Officer for Acute Services, with particular oversight of our rural general hospitals. We were also fortunate to be able to appoint two new Heads of Strategy, for NHS Highland and for the Highland Health and Social Care Partnership services: Lorraine Cowie and Tara French.

During 2021-22 we also opened two new community hospitals: Broadford Hospital on Skye and Badenoch and Strathspey Hospital in Aviemore. In the coming year we will open the new National Treatment Centre in Inverness. We continue to engage closely with communities about new buildings and services, such as the proposals for a replacement for the Belford Rural General Hospital, serving Lochaber, and Hubs to support community care in Caithness. On Skye, we are gathering stories of people’s experience of health and care services – what a good day looks like, and where things could be improved – to help us crystalise the vision of a new Care Village.

Case study: Broadford Hospital

The new hospital provides a wide range of services: the ground floor has a range of consultation and treatment rooms, a spacious emergency department, physiotherapy and occupational therapy, chemotherapy, an imaging department (x-ray and ultrasound) and a maternity unit. The ward is on the upper floor, which provides beautiful views for anyone who has to stay in hospital.

Following engagement with the community, we worked to include a renal dialysis service at the hospital. This was initially started as a new service for Skye and the surrounding area, saving patients from frequent lengthy trips to Inverness. It has now moved into the new hospital, where four in-patient rooms ensure that patients will continue to access dialysis treatment closer to their homes.

We also worked with partners to make sure their needs were considered, with the result that the hospital will also be a base for the Scottish Ambulance Service.

Highland Health Board

Broadford Community Hospital Exteriors

Badenoch & Strathspey Community Hospital Lounge

1.2 About NHS Highland

NHS Highland is one of 14 territorial boards in NHS Scotland and covers the Highland and Argyll and Bute council areas. We provide services across 40% of Scotland's land mass and service a population of over 330,000. We have over 10,500 people who work within NHS Highland, Argyll & Bute. This does not include our important colleagues who are employed by councils and other partners. Our services are delivered across 4 acute sites, 17 community hospitals and numerous community settings. We have 87 care homes, of which 65 are independent. We have seen an increase in care homes closing permanently closing in the past year.

We are unique amongst territorial boards in having a lead agency model for health and social care in the Highland Council area, with NHS Highland having responsibility for delivering adult social care. In Argyll and Bute, we operate as part of an Integrated Joint Board.

The diverse geography includes Inverness, one of the fastest growing cities in Western Europe, and 36 populated islands (23 in Argyll & Bute and 13 in Highland). Gaelic is spoken in some areas.

Our population lives with some challenges, including areas of deprivation and inequality and issues arising from fuel poverty, transport difficulties and the rising cost of living. People living in the NHS Highland area are also older than the Scottish average and can have increasingly complex health and care needs. The economy is heavily reliant on tourism, with seasonal work being common.

It is also an area often cited as having one of the best standards of living in the UK, with clean air, access to a beautiful outdoor landscape, and engaged communities. People are proud of their area, and we want to work with them to find new ways to support delivering health and care as close to people's homes as possible.

1.3 Structure and Governance arrangements

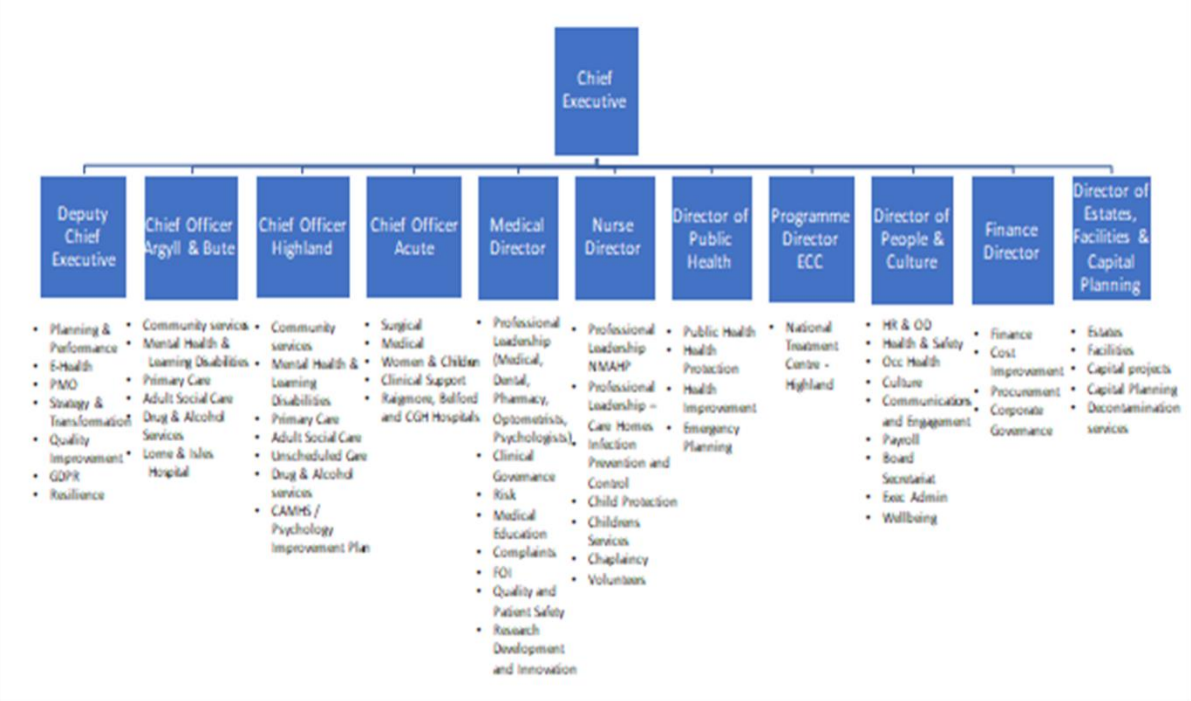
NHS Highland is managed by a Board of 22 members, made up of 17 non-Executives and five Executive Directors who are accountable to the Scottish Government through the Cabinet Secretary for Health and Sport. Executive Directors who are also board members are the Chief Executive, Board Medical Director, Director of Finance, Board Nurse Director and Director of Public Health.

The Board is responsible for the strategic planning of health services and the development of measures to improve the health of people in the Highlands and Argyll & Bute. The Core Governance Committees are: Clinical Governance, Staff Governance, Finance, Resources and Performance, Highland Health and Social Care Committee and Audit Committees. These Committees are responsible for regularly reviewing and updating relevant policies in each of their areas of responsibilities on behalf of the Board. Responsibilities for Health and Safety are reported directly to the Staff Governance Committee. The Remuneration Committee and Pharmacy Practices Committee also have a direct reporting link to the Board and perform a more limited assurance role. The Board also receives advice and information from the Area Clinical Forum and the Area Partnership Forum. Board meetings are held every two months. Meetings continue to be held virtually, with members of the public able to attend online and a recording posted online afterwards.

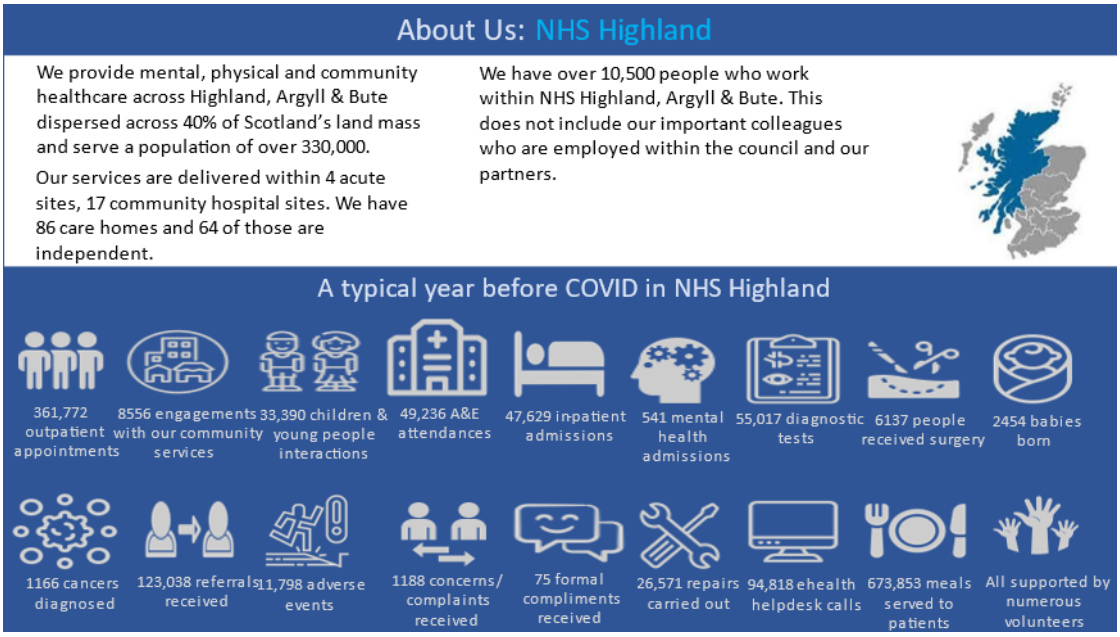
The Board includes two Local Authority areas, Highland and Argyll & Bute. Operationally, activities are managed by the Highland Health and Social Care Partnership (co-terminous with

The Highland Council area) and Argyll & Bute Health and Social Care Partnership (co-terminous with Argyll & Bute Council area).

The organisational structure promotes cross-service working. The structure has moved away from a locality model and aims instead to allow for an overview of services across the whole of the NHS Highland area, to better manage the impacts of changes across the system.



1.4 Priorities, Approach and Objectives for 2021/22



Managing During Covid

Over the course of this unprecedented challenging year, everything possible has been done to continue to deliver quality services and maintain safe environments for patients and colleagues.

To ensure that NHS Highland continued to respond to ongoing changing risks and national guidance during the COVID-19 pandemic, at both an operational and strategic level, the corporate governance arrangements were reviewed and modified on a regular basis.
The Clinical Experts Group was established to ensure an open and transparent overview of decision making and resource allocation. Very quickly we also established a gold command, chaired by the chief executive with executive support and senior clinical leadership, along with silver and bronze. In Highland we had this in place far in advance of some other boards.

Early in the pandemic, NHS Highland enacted measures to free up capacity to cope with the unprecedented demand, postponing non-urgent elective care, stopping accepting patient referrals other than for urgent or suspected cancer cases and closing our minor injuries units to focus all efforts and resources on treating COVID-19 patients.

Throughout the pandemic NHS Highland has liaised closely with Highland Council and our regional partners to agree the management of referrals and new models of care and to ensure a consistent workforce approach. Thanks to partnership working with NHS Grampian a number of urology cases were managed in Dr Gray's and some HPB cancer patients were treated in other boards within the North of Scotland through a mutual aid arrangement. Some surgical patients also went to Golden Jubilee National Hospital (GJNH) and Tayside (OMFS).
NHS Highland developed a structure to support delivery of health and care to respond to Omicron and the continuing pandemic situation which we continue to use as we move from this.

Bed modelling data for the Omicron variant of COVID-19 indicated that NHS Highland would be overwhelmed if the ranges given were a reality. This was a range from 6-109 beds being utilised for COVID patients. Fortunately, the whole system modelling produced by PHS did not reflect our actual situation until very recently therefore was limited in its application for us locally. The workforce challenge was the biggest factor in responding to the increased capacity and demand issues that went well beyond our bed-based services.

A system escalation framework was placed around our health and care system to support collaborative working and collective understanding of what was going on in our system. This helped address the challenges we faced and placed rigour around our decision making out with our normal parameters of working. The system escalation framework was devised across 5 levels to give a guide as to how our system is responding and how we should then respond as a Board. This continues to be applied allowing us to work within a framework that is organisationally understood and giving structure in how we respond. It described our response, the structure and the decision making models we adopted to ensure we responded appropriately ensuring due diligence.

The framework ensured we were supporting our Senior Leadership teams (NHSH as a whole, Acute, North Highland and Argyll & Bute) to work with accountability and governance whilst supporting whole system challenges through our Executive Directors Group System Pressures meeting.

Our whole system Senior Leadership Team (sysLT) was stepped up to twice weekly and our EDG system pressures meeting to weekly supporting our response, our local structures having daily system pressures meetings to manage the wave and system pressures. This is a system that we can step up and down as required to manage our challenges. This worked well for us in managing the wave of omicron and responding to some of the ongoing pressures.

Vaccination and Testing

NHS Highland has successfully delivered both the 2020/21 influenza vaccination programme and tranche 1 of the COVID vaccination programme. Uptake rates for influenza vaccination were

75% among the eligible population and for COVID vaccination among people aged 18+ there has been a 94% uptake for first doses and 90% uptake for second doses.

In the early days of symptomatic PCR testing roll-out from summer 2020, it became apparent that the UK wide service would not meet the needs of the dispersed populations in Highland's rural and island communities. Scoping activity, including a comprehensive community online survey which generated 600 responses, was carried out in the autumn of 2020. This resulted in the development of a range of additional community testing facilities.

In addition to existing fixed sites in Inverness, walk in centres were established in Oban and Wick and mobile testing units were located across the NHS Highland area. Partnership working with government and with Scottish Fire and Rescue enabled fire station testing sites to be set up widely and these subsequently replaced most mobile units.

NHS Highland continues to deliver tranche 2 of the vaccination programme with a mixed model of delivery aiming for high uptake and short timescale. Development of the future model for all vaccination programmes is also under way. This will move to a board run service which is both person-centred and designed appropriately for the locality where it is delivered. Along with vaccination services delivered by the board, there will need to be primary care delivery, where appropriate.

The Board is committed to move towards a new way of working in relation to vaccination delivery. The mixed model of delivery that has been necessary for tranche 2 has been challenging but has given us an opportunity to apply a test of change in various areas.

We are finalising our plans for a board run service with an overarching governance structure but clear operational lines of accountability within the remit of Chief Officers for Argyll and Bute and Highland.

Vulnerable groups have been prioritised and vaccination has been carried out at all care homes. Communication and, in some areas, vaccinator capacity have been challenging as the board takes over provision from general practice over a huge geographical area and large number of vaccination sites.

A strategic commission for Tranche 3 has been developed with clear governance and accountability through the Vaccination Programme Board that meets twice monthly. This Strategic Commission reflects NHS Highland's requirements for the provision of vaccination across the Board area for the coming year and takes into account our unique geography.

Impact on Performance - Outpatients

Unfortunately, the number of patients who are waiting over 12 weeks has increased to 10,070 patients at the end of March 2022. We currently are receiving around 13,500 referrals per month which has increased around 3,500 since the start of COVID.

Significant work has taken place in the redesign of outpatients which is changing the way patients are being seen, using face to face (74%) and virtual consultations (26%) and more patients being seen by non-medical personnel than ever before. Social distancing and requirements for enhanced cleaning and reducing the potential for cross contamination as a result of the infection control procedures aimed at reducing the unintended spread of infection has led to a reduced availability for face-to-face appointments during this accounts period. We have developed a Highland Urology Hub which has streamlined the process to develop a one-stop-shop for Urology patients where they can have a clinic appointment, diagnostic tests including scanning, and even treatment all on the one day. This has significantly reduced numbers of journeys to the hospital and improved patient care.

A fourth Endoscopy room has been developed and is now operational which has increased capacity for outpatient Endoscopy. This is leading to improvements in cancer performance.

Further efficiency gains need to be developed including greater use of patient induced return appointments and improvements by the departments in the administration of outpatient appointments. Pre-operative assessment capacity requires to be increased over the next year in preparation for the national treatment centre coming online in early 2023. In particular, there is a need for an increase in Orthopaedic pre-assessment capacity.

Activity projections have been submitted as part of our remobilisation plan (RMP4) and the new submission to take us to September 2023 which describe how NHS Highland will increase outpatient capacity as it is recognised that we currently have an excessive number of patients waiting longer than 12 weeks for a first appointment. There is a need to develop the one hospital / four site strategy to include the RGHs maximising opportunities to see patients at any of our sites.

Impact on Performance - Elective

The number of patients waiting over 12 weeks has increased from 3,920 on 31 March 2021, to 4,933 on 31 March 2022. This is a continued increase as a consequence of the COVID-19 pandemic which has significantly reduced non cancer elective operating capacity this year.
Staffing of additional critical care facilities has been supplemented by theatre staffing which has resulted in several theatres remaining closed throughout this year.

Our inpatient and day case operating list has been stratified by clinical priority order and a clinically led structure has been put in place to ensure that patients with the greatest clinical need are prioritised for surgery.

NHS Highland has seen a significant pressure on our critical care services including ITU and surgical high dependency areas. We have required to run two ICUs this year – one for non-COVID patients and a second for COVID positive patients. Despite this, capacity has been severely limited for elective admissions to these areas and priority has been given to emergency patient care. We quickly developed our surge capacity to allow an increase from 8 ITU beds to 40, though this maximum was not required.

There is a need to improve flow within Raigmore Hospital, reducing the number of delayed discharges and patients waiting for community beds or Social Care placements. Surgical beds in the long term require to be ring-fenced for surgical patients.

We need to increase theatre capacity until we reach the point where we have all elective theatres scheduled from Monday to Friday. The recovery programme will build on the theatre cross-cutting workstream ensuring efficient utilisation of theatre capacity across the NHS Highland area.

The ongoing development of the robotic surgical service will continue with a view to increasing utilisation and skills development for local surgeons.

A recovery plan for elective care as part of our Annual Delivery Plan is being developed which will span the coming three-year period and will map out the return to expected performance target position following the guidance and direction of the Scottish Government Access Support Team. A high level recovery plan has been submitted to Scottish Government (SG) in March 2022 that will bring us to 90/95% of 2019/2020 levels of activity. Significant work is required to develop a robust approach to recovery balancing our workforce and capacity challenges.

Key principles of this will be adopting the Centre for Sustainable Delivery (CfSD) work systematically through our system, maximising our utilisation of our sites, clinical prioritisation of those patients who need us the most and supporting our workforce through this.
Regional and National workforce models will be developed particularly for services with a less resilient model of workforce to ensure services can be delivered as close to home as possible for our local NHS Highland and Argyll and Bute populations. The Argyll and Bute Health and Social

Care Partnership (HSCP) continues to focus on the remobilisation of services in line with NHS Highland Remobilisation 4 plan.

The HSCP pathway and reliance on NHS Greater Glasgow and Clyde (NHS GG&C) for specialist hospital services, required that our remobilisation plan was agreed in tandem with NHS GG&C. The scale and pace of resumption of normal services by NHS GG&C remains focusing on Priority 1 and 2 activity. Within NHS GG&C, their RMP4 and new plan to September 2023 like the Highland plan reflects that Elective theatre capacity continues to be significantly reduced to support the demand for unscheduled care.

The impact of the pandemic on waiting lists and waiting times for scheduled care (priority 3 and 4) has been significant as this activity was cancelled during lockdown and continues to be a challenge at March 2022. Working with NHS GG&C, we are redesigning services and increasing activity within Argyll and Bute to bring our local outpatient waiting list down and reduce waiting times.

The National Treatment Centre- Highland (NTC-Highland) will be a purpose-built facility providing:

- Uncomplicated hip and knee replacement surgery (ASA 1&2)
- Foot and ankle surgery
- A full range of ophthalmic care including outpatients and surgical treatment

The facility will have:

- 24 beds (3 flexible use for ophthalmic patients)
- 5 operating Theatres
- 13 consulting rooms including 2 teach/treat and 4 virtual consulting rooms
- A full range of ophthalmic diagnostic and treatment services
- A patient / colleagues' café

It will be part of the national network of treatment centres across Scotland but is unique in so far as the facility is being built on the Inverness Campus site across the A9 and away from the main Raigmore Hospital site. Work is underway to develop the service models for ophthalmology and orthopaedics to maximise the efficiency of the building and to orientate colleagues to new ways of working to reflect single occupancy rooms and to deliver significant improvements in orthopaedic patient lengths of stay.

Planning for this new facility commenced in earnest in 2017 with the Financial Business Case (FBC) approved by the Board and SG in early 2020 allowing construction to commence later that year. Construction is well advanced and undertaken by our Preferred Supply Chain Provider Balfour Beatty. It is anticipated that the building works will be completed early in early September 2022 with the facility becoming operational from the end of early 2023. This will have a major impact on our elective waiting list once it is operational.

An additional 202 colleagues will be needed over and above those colleagues that will transfer in or rotate into the NTC for professional development reasons. A phased approach to recruitment is underway and this is expected to be completed by July 2022.

Impact on Performance - Cancer

Detect Cancer Early (DCE) data shows NHS Highland performing at a similar level to NHS Scotland. Breast and colorectal mirror that performance whilst lung cancer diagnoses at stage 1+2 are slightly lower than the national average.

There has been a slight decrease in Stage 1 and 2 cancer diagnoses in breast and colorectal compared to last year with the most likely single factor being the absence of screening in Spring/Summer2020 due to COVID. As screening has restarted these figures should improve. Lung cancer performance in NHS Highland is similar to last year.

31 day cancer waiting times targets are consistently achieved at the 95% level. Where this performance has not been achieved, it was due to a decrease in theatre capacity and prioritisation according to diagnosis which saw some cancer patients have surgery delayed for up to 3 months.

62 day target performance has been improving over this accounts period. We have redesigned our referral and diagnostics pathways and the trend is improving (58% May 2021 to 85% August 2021). We aim to maintain this standard and ultimately to push on to achieve the target of 95% and higher.

The establishment of Urology as a Bringing It Together specialty within the Scottish Access Collaborative has been a significant catalyst for much of the improvements within this specialty. We have a newly created Highland Urology Centre with dedicated scope facilities and a revamped prostate referral pathway. Our waiting times performance in urological cancer was poor when compared to the rest of Scotland (and Scottish performance in urology is the lowest of all tracked cancers). Bringing It Together We are now above average for 62 day performance.

We are about to launch access for GPs to CT scans for suspected cancer which we hope will benefit patients with complex and atypical presentations of cancer.

We have installed a surgical robot which should improve care for colorectal and gynaecology patients and may allow us to repatriate care of prostate cancer patients from NHS Grampian allowing more convenient treatment closer to home.

Mental Health

Throughout NHS Highland, mental health services have continued to provide in-patient and community provision during the pandemic albeit, by necessity, there have been changes to the way this has occurred. In Highland HSCP, there has been a reduction in in-patient capacity and a mixed model of face to face and Near Me services within the community.

More recently, the continued reduction in in-patient capacity has also been related to a significant programme of ligature reduction work across the wards within New Craigs Hospital as well as the ongoing challenge of mental health nursing recruitment which is a national and local concern. This recruitment challenge extends to psychiatry and psychology, with proactive recruitment plans and innovative approaches being explored as part of our overall strategy and improvement work.

To support admission avoidance and to promote a home first approach in the future, the service has been working to establish new and enhanced provision of community care both in relation to urgent and primary care in each of the localities with the aim of ensuring effectively integrated services to meet the needs of our communities.

We developed and implemented a new Mental Health Assessment Unit as a test of change and have now agreed this as a permanent change. Adult Learning Disability day services that were building based have been redesigned to provide a range of opportunities in different settings (online, at home, in community settings).

For North Highland, a model of support to colleagues in Primary Care has now been agreed and recruitment is underway. Workers will be based in all GP clusters across Highland to provide

first contact mental health triage, assessment and support. It is anticipated that this service will be fully operational by March 2022.

To ensure a framework for improvement work, we have created Action Plans for all services using the Essentials for Safe Care as a framework and a method of prioritising the work required. The Mental Health & Learning Disability Improvement & Transformation Plan summarises all these action plans and sets out the actions that we will complete over the forthcoming months.

We have now reached agreement with key stakeholders in the Highland Council and Police Scotland to develop an all Highland, all age Mental Health & Wellbeing strategy and this work will commence in the forthcoming months.

Argyll and Bute HSCP participated in stage one as part of the national accelerator site with NHS Highland supporting Early Interventions in Psychosis Work Stream in collaboration with Healthcare Improvement Scotland/SG.
We have also continued to work with the Scottish Government to develop a psychological therapies business case that will not only help us meet the long waits within Argyll and Bute but also allow us to expand and meet capacity in the future.

We continue to develop our Emergency and Urgent Care Service in Argyll and Bute HSCP and we are on track to meet our commitment of 14.8 wte by 2022. The teamwork in close collaboration with A&E, Police, SAS, CMHTs and MHO colleagues to ensure that all service users are provided with a specialist emergency or urgent assessment within 2 hours of referral to the team, where appropriate.

We have put in place clear improvement plans in Child & Adolescent Mental Health, Peri-Natal and Infant Mental Health and Psychological Therapies (diagnostic plan).

Progress is monitored regularly at our Performance Recovery Board and will also be reviewed at the Mental Health Programme Board which had its first meeting in early February 2022 and now meets monthly.

We have now appointed a Clinical Director for Psychology who has commenced post on 7/2/22 and a Clinical Director for Children and Adolescent Mental Health Services (CAMHS) who will commence post within the next 3 months.

A Clinical Director for CAMHS has been interviewed and it is hoped that they commence post soon to lead the service through significant change. Engagement appointments are now planned to tackle the backlog with a robust approach to waiting list management within CAMHS, lived experience is embedded and robust validation of the waiting list has been completed.

For Dementia Post-Diagnostic Services (PDS), a proposal has been approved to continue to commission Alzheimer Scotland to provide PDS as it is unlikely that any other provider would be in a position to deliver the service to the standards required within Scottish Government timescales. We are currently developing the contractual arrangement which identifies the total funding allocated to Alzheimer Scotland specifically for the delivery of PDS across North Highland area and more specifically where this is based within individual localities. This will ensure improved governance arrangements; parity of service as well increased access to PDS and ultimately improved outcomes for people with dementia across the North Highland area. This will be in place in 22/23 should continued funding be available.

In the next year and in order to build capacity into the existing specialist mental health pharmacy workforce it is essential that we train more pharmacy technicians. Our specialist mental health pharmacy service development plan includes a commitment to develop the clinical roles of the band 5 pharmacy technicians to provide support to the clinical pharmacists with activities such a compilation of medication histories, production of covert medication plans and compliance needs assessments.

This will free up clinical pharmacist capacity to concentrate on more complex aspects of patient care. Training an additional band 4 pharmacy technician will ultimately enable a further reallocation of tasks to maximise the use of the skill set of each team member.

As the new perinatal mental health service is being developed within Highland HSCP there is not a specialist mental health clinical pharmacist embedded within the multidisciplinary perinatal team and we will explore this. Investing in dedicated specialist mental health clinical pharmacist input to the perinatal service will improve the Multi-Disciplinary Team (MDT) capability and capacity with respect to medicines use, thereby releasing medical and nursing capacity to focus on other aspects of patient care during the perinatal period.

Public Health

COVID has remained the principal focus within Public Health, but there has also been development in other areas.

Testing for COVID has expanded with continued development of the fire station testing service and expansion of the availability of PCR kits by post and courier. Asymptomatic lateral flow testing has been delivered across both council areas with mobile and fixed sites as well as through postal and pharmacy collection. The contact tracing service has been strengthened.

The effects of COVID on wider society have been acknowledged by the development and Board approval of the strategy and action plan for social mitigation. Work has started on implementation of the strategy. The theme of health inequalities, which is at the forefront of social mitigation work, features within public health input to the board strategy along with issues such as prevention, sustainability and mental health improvement.

Public health services have remobilised but, for some, the capacity is limited by the demands of COVID. Screening services which stopped for COVID are now back delivering full services.

We have established a COVID Rehab and Recovery Group that will report into the Performance Recovery Board.

Primary Care

General Practice continues to deliver exceptional patient care in challenging times. We have vulnerable practices in Caithness (Wick), Alness & Invergordon (in process of transitioning to 2C), 10 GP vacancies across 2C practices and although recent recruitment appointed to 3 posts, there are still significant gaps remaining. The Scottish Rural Medicine Collaborative has had a good response to recent recruitment drive, so NHSH is still a major supporter of the collaborative.

The Out of Hours Service continues to submit weekly reports to SG. We continue to have pressures in allocating shifts and there are significant pressures over the 2x4 day bank holiday periods which we are working collaboratively to address.

Primary Care dentistry will not return to pre covid levels of care for a very long time. There is potential impact on access to NHS dentistry associated with the outcome of British Dental Association/SG negotiation of the General Dentist Services contract and we must be mindful of this. We also have the added challenge of recruitment in Highland which has intensified as a consequence of COVID.

Inequalities in oral health will have increased and there is an associated need to focus on oral health improvement programmes including Childsmile moving forward.

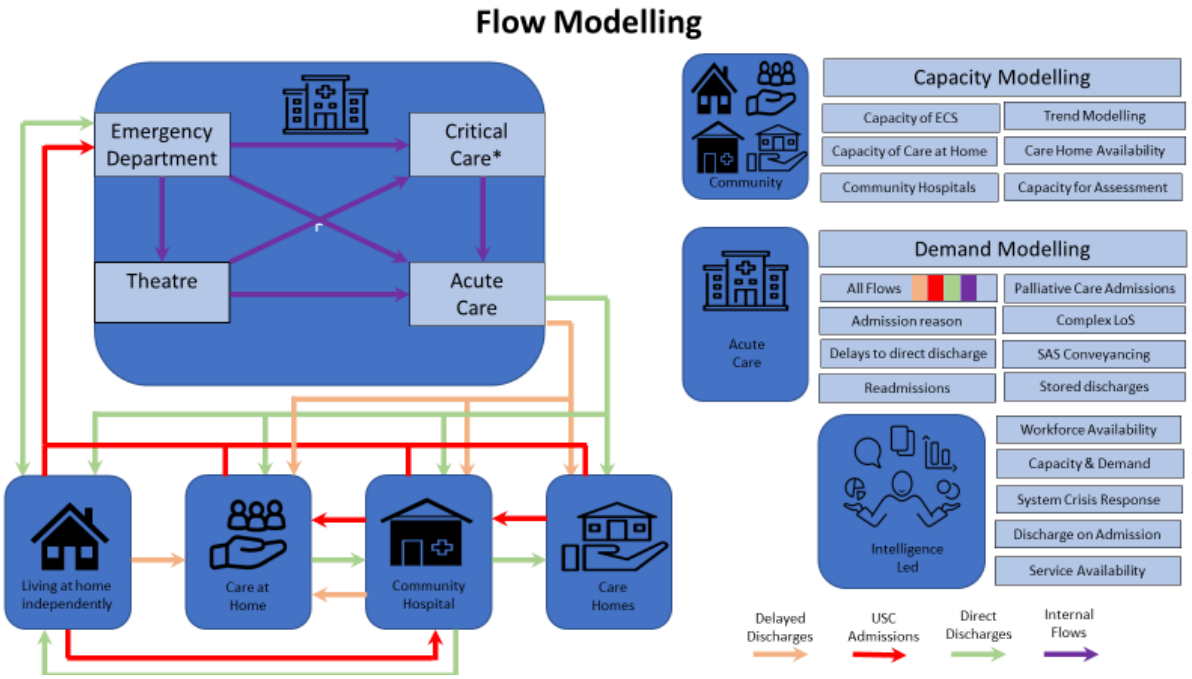
In terms of Community Optometrists, they have remobilised but not all practices are delivering pre-COVID capacity due to ongoing PPE and social distancing requirements.

Whole System Working – Unscheduled Care

Redesign of Urgent Care (RUC) Phase 1 was implemented in line with the national guidance in 2020 and, on 1st December 2020, the Flow Navigation Centre (FNC) function commenced as planned. A phased development of the FNC alongside the 2-3 year implementation of the wider RUC programme is envisaged with the initial focus being on supporting safe and effective scheduling to Emergency Departments and Minor Injuries Units. With this in mind, and due to COVID learning we have commenced a review in March 2022 with regards to the FNC.

Since its inception, the FNC has been consistently discharging over 30% of patients to self-care (which includes advice to contact other sources of support on a non-urgent basis, e.g. GP, community pharmacy etc.). The majority of patients requiring face to face assessment are referred to Emergency Departments or Minor Injuries Units with most referrals to Minor Injuries being on a planned basis to support the management of flow.

Resolving the issue of capacity and demand with regards to delayed discharge and bed capacity and demand requires the co-operation of organisations across NHS Highland to co-ordinate a region-wide initiative to promote the closer collaboration that can make a difference. Delayed discharges remain a major issue for hospitals throughout the NHS Highland area. The occupation of beds by people who are well enough to go home or continue their recovery in another healthcare setting has knock-on effects throughout the entire hospital system.



Ultimately, it can prevent hospitals from being able to admit new patients in urgent need of care. This is a problem that affects all our acute and community hospitals. There are on average monthly over one hundred people on our wards who did not need to be there at any point during 2020/21. Evidence shows that going home is better for patients, as they recover better outside hospital once they no longer need the specialist care they receive there, while making more beds available will help us treat more people more quickly, particularly during the winter months in which illness and accidents are more common.

New pathways for the FNC will be established as we move beyond the next 3 months for the Custody Suite Community Pharmacy; Optometry and Musculoskeletal services in line with national RUC Phase 2 developments.

Highland is establishing a Pathfinder project for this programme and working with the national team to assess local needs for delivery. This will include current priority work for rapid improvement which is focused on a whole system approach to the management frailty aimed at preventing frailty in the community; reducing admissions and, where people are admitted, reducing their length of stay in hospital.

Our existing improvement plan for discharge planning is part of the Unscheduled Care programme; this is now being re-energised by fully aligning it with the national Discharge without Delay (DwD) programme and ensuring that deliverables identified through DwD self-assessment are built into a single whole System plan for improvement to address the current position with delayed discharges and to ensure that processes are improved in ways that prevent/minimise delays in the future and will be one of our priorities over winter.

The wider RUC programme activities in the national programme will ensure that transformation of our pathways and systems in conjunction with those of partner agencies supports us to take a multi-agency, multi professional approach to scheduling; directing patients to the most appropriate professional and place for their needs and allowing decisions to be tailored to the patient not the service they arrive to.

Alongside this, NHS Highland continues to work closely together with The Highland Council on developing and taking forward transformational change as an integrated system. Recognising the sustainability challenges, both financially and in relation to growing demand for services alongside recruitment challenges, a transformation programme has been established. The programme focuses on both the financial savings requirement and the need for radical change in our thinking and approach to enacting a 'person-led, not system satisfying' vision to ensuring outcomes for people are at the centre of everything we do.

To take on this challenge, work is now underway on setting our future strategic direction informed by the principles of health and social care integration. The programme also seeks to understand and explore how we instil a learning-based approach and culture to build future capacity for transformation.

We will work collaboratively across Highland, Argyll & Bute to achieve this. Argyll & Bute have recruited an Unscheduled Care Lead to drive multi-disciplinary working.

Together We Care – Our Strategy

Together We Care
Building a brighter future for health and care 2022-2027

We are developing a strategic plan “Together We Care” to underpin NHS Highland’s approach to deliver Scotland’s vision for achieving sustainable, quality health care services and deliver a healthier future for everyone.

A clear and well thought out strategy will help achieve the vision, principles and values of NHS Highland by sustaining safe, effective patient care. A sound strategy will help protect the clinical, financial and operational sustainability of the services that we provide for our population. It is clear that future models of delivering health and care will need to be different and we will be engaging our population, people and partners in this whole system programme of strategy, transformation and planning with purpose.

The strategy will be a set of choices and principles designed to help us achieve long-term goals based on our agreed strategic imperatives. It will influence how resources are allocated and how our people prioritise their time. If we communicate the strategy successfully, it will help our

people understand the direction of NHS Highland. Through collaborative strategic planning at our board, we can shape our population's care into the future. Our role will include articulating ambitions, gauging possibilities and assessing risks. It will also reaffirm our ethos based on valuing our people and put our people at the centre of the development of the strategic plan.

Through the strategy development we want to embed a culture of ownership and continuous improvement to ensure our workforce can fully contribute to achieving the best possible health and care based on evidence and best practice.

The strategic plan will set the direction for NHS Highland and enable us to embed a shared strategic intent in line with Scotland's Framework for Recovery and the three-year integrated delivery plan to be submitted to the Scottish Government in March 2022 although our 5-year strategy may overtake this. It will be fully cognisant of the role and responsibilities of the lead agency in North Highland and the IJB in Argyll & Bute; we will focus on the areas where we need to develop fully integrated approaches.

It will embed our role in care as a "community" responsible organisation to promote equality and protection for the most vulnerable in society and investing in the future of our children and young people by ensuring active engagement adopting a "your care, your future" approach.

Starting with our most pressing challenges highlighted in RMP4 around waiting times, access to optimal care and support for vulnerable parts of our society including the young and the elderly, we need to develop whole system integrated care pathways to ensure that services are consistently high quality, efficient and safe. The strategy will only be the first stage of our future to support our organisation and be embedded through development of an implementation plan and by continual active performance management.

Performance Management

NHS Highland has recently reviewed its performance and quality functions and the associated arrangements for managing this overall within the organisation. As part of the governance requirements, it will provide clarity throughout the organisation on accountabilities and responsibilities. The performance and quality framework seeks to describe the NHS Highland approach to managing corporate performance and quality effectively through the delivery of this

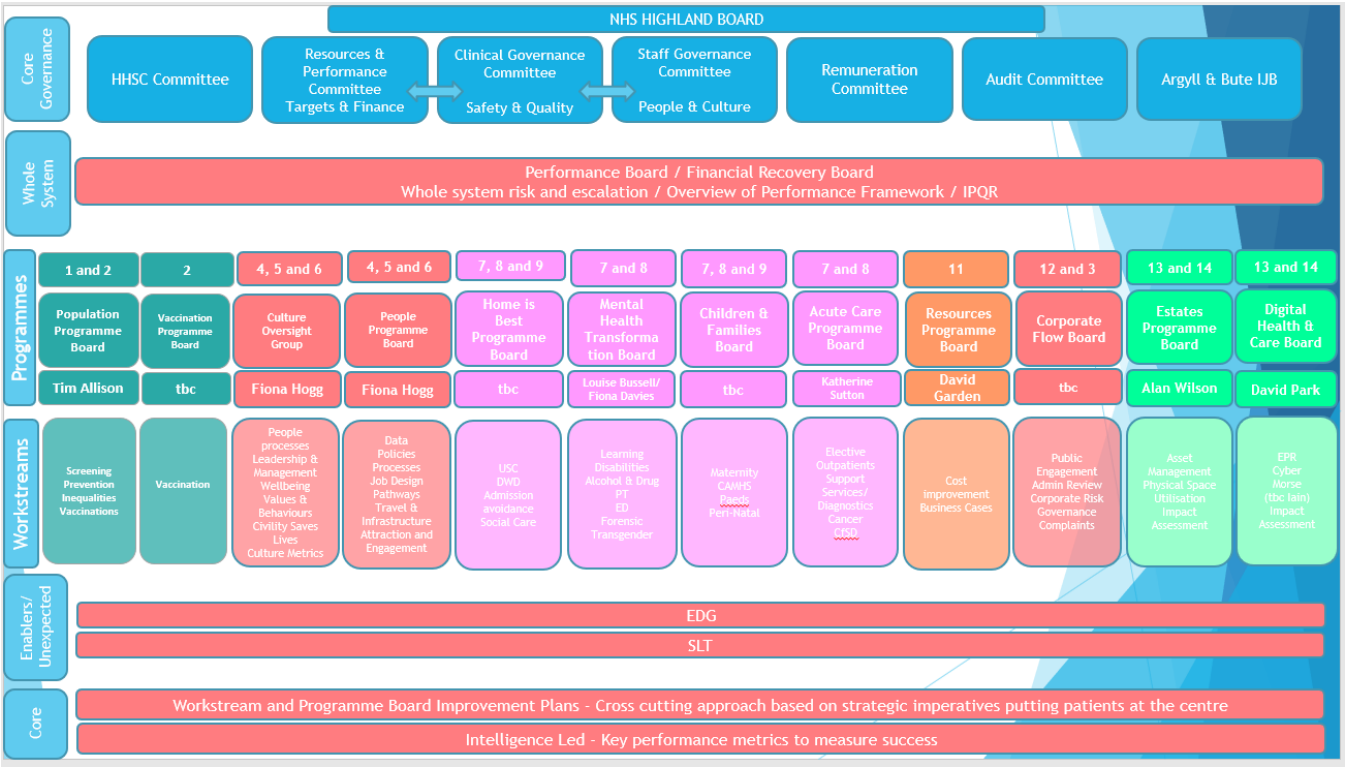
framework. The definition of performance and quality within NHS Highland incorporates our 5 domains of population, people, pathways, performance and progress.

The Framework has been developed to ensure that an integrated approach to managing quality and performance is taken and there is clear visibility and lines of accountability from the Board down through to service level to ensure NHSH is best placed to deliver all required standards. NHS Highland's strategy will set out the direction of travel and the performance framework is the mechanism to track and ensure delivery with the aim of providing internal and external assurance. Whilst the framework describes the links to individual accountabilities and the contributions that all colleagues make to the delivery of performance, it does not deal directly with individual performance management. This is covered within the NHS Highlands policies and procedures relating to our people.

It is recognised that there is a need to develop the performance culture of NHS Highland through an increased use of intelligence including outcome measures providing wider insight beyond headline metrics and, in light of this, the role of the intelligence teams and the provision of information will be reviewed and developed in line with this future vision.

All actions and interventions relating to adverse performance will focus on ensuring the patient is at the centre and that all actions we take measure success for our population and are delivery focussed and proportionate to the level of risk identified.

The model is displayed below that captures our core workstreams and how they relate to our Performance Recovery Board and our governance committees.



The annual operating plans have already started to be developed in line with our recovery and will be presented to the Board as a draft in May 2022 with submission to Scottish Government in July 2022. It will be fully cognisant of the role and responsibilities of the lead agency Integration Authority (IA)in North Highland and the Integration Joint Board (IJB) in Argyll & Bute; we will focus on the areas where we need to develop fully integrated approaches.

We now have our patient pathway programme boards in place - Home is Best Programme Board, Scheduled Care Programme Board, Mental Health Board and Vaccination Board in place.

Our Children and Families Board has not commenced as yet but we have put in place individual workstream boards for Child and Adolescent Mental Health Services/Neuro-Developmental, Maternity and Neonatal and Peri-Natal Infant Mental Health as we agreed these needed ongoing individual attention at present.

Our Performance Recovery Board continues to meet weekly and is planned in advance with a reporting template used to ensure we are providing oversight across all key areas.

Sector Performance Reviews are carried out monthly that culminates all of the workstreams under that sector. These are chaired by the Deputy Chief Executive and are attended by Executive Board members and other EDG members.

A service planning framework has also been introduced to provide ownership at service level ensuring appropriate plans are in place with clear oversight and governance at the appropriate programme boards.

With new community management and leadership structures in place we are engaging with the current GP clinical leadership cohort to redesign the GP leadership and with this gain greater input and involvement enabling better supported and connections across our system. We are inviting the GP Sub and members of the GP leadership team to have appropriate involvement in service development with representation on appropriate wider system programme boards, primary care modernisation programme boards and on many working groups.

It is acknowledged that the clinical interface group requires restructured to improve our primary secondary care relationship. Further work is being undertaken to improve effective communication with GPs to make sure they feel informed and engaged. With these processes progressing we aim to improve our engagement with the wider GP and MDT to help inform the clinical direction moving forward and optimise integrated ways of working, ensuring best outcomes for our population.

At board level we have redesigned our Integrated Performance and Quality Report (IPQR) that gives the board an overview of performance and quality across NHS Highland bi-monthly. This report is compiled from data considered at our governance committees along with comments, risks and mitigations from our executive leads. The report can be found online through the following link:

Link to IPQR January

Link to all Board papers March (IPQR on page 183)

Care Homes and Care at Home

The ongoing restricted access to available but unstaffed vacant beds continues to impact on hospital flow. The staffing situation across a number of in house and independent sector care homes within North Highland remains fragile.

Providers are still not able to staff to full capacity. This is due to a lack of confidence in being able to appropriately staff to the bed complement arising from acute challenges in recruiting and retaining colleagues, alongside regulatory implication concerns.

Providers have intimated that they are adopting a significantly more risk adverse approach to service provision, which will inevitably see a reduction in available beds. Completion of an

extensive “pandemic review of key issues and risks” for the Care Home Oversight Board is to be undertaken with the emerging learning to be adopted.

Care-at-Home is currently the most critically fragile area of the health and social care system for adult social care. There are a number of significant issues affecting all care at home providers at present, these being around workforce recruitment and retention, which is linked to level of pay, working patterns and the lack of certainty regarding the number of hours of employment.

This current issue is consistent with the picture at a national level but does need to be balanced against the significant additional growth seen during the pandemic. NHSH has been working with independent sector care-at-home colleagues to address these significant challenges. Ongoing and participative dialogue continues as we try to stabilise service provision. An action and recovery plan has been agreed with the sector.

The Scottish Government has confirmed care at home stability and capacity as a priority area and have requested increased oversight of this area. Across North Highland, unmet need is still an issue with significant increases during the last 3 months with unmet need currently reported to the SG in excess of 1800 hours. Significant officer input to support all external care-at-home providers has been agreed.

Payment is now on a planned care delivery basis during winter with a service review date of 31/1/22.

The recent SG directive to increase the base hourly minimum pay rate from £9.50 to £10.02 per hour has been implemented and was effective from 1/11/21 for care-at-home.

There is ongoing sector dialogue, support and provision of mutual aid. General, Ongoing staffing challenges experienced across both in house and commissioned services.
Increased number of Adult Protection issues have arisen due to staffing challenges in service delivery. Complex care and support at home is an emerging cost pressure with providers experiencing stressors and recruitment concerns for supporting younger adults with complex needs. There is rate differential widening between care-at-home and support work.

Pressures continue to be experienced by both commissioned and in house adult social care services and there continues to be significant risk and fragility across this provision. Pressures exist on the Social Care and the Social Work Services workforce.

Moving forward within Argyll & Bute they have set up a Care Homes and Housing Programme Board to develop a strategic vision for care homes and housing across Argyll and Bute taking into account national strategies and local solutions for older adults within Argyll and Bute with effective local engagement.

The Board has an established and well supported Care Homes Oversight Group and established structure to maintain regular links with, and support for, care home providers and the Oversight Group has commissioned specific pieces of work including learning reviews in order to support improvements across the sector.

Commissioned care home and care at home provision in north NHSH continues to be extremely fragile with significant recruitment, retention and staff wellbeing issues impacting on capacity, availability and quality.

This fragility has been exacerbated by numerous recent Covid-19 care home closures (peak of 54/69 care homes) and outbreaks (peak of 15).

These services continue to be a critical and whole system priority for NHS Highland, both in terms of current operational actions and supports but also in terms of strategy and planning of short, medium and longer term actions.

Key objectives across care home and care at home activity are being progressed to: stabilise provision, build resilience, grow / release capacity, improve efficiency / processes.

National Care Service

The Scottish Government commenced consultation on a National Care Service on the 9th August 2021 with a final submission date of 2nd November 2021. This was in response to the recommendations of the Independent Review of Adult Social Care (Feeley report) which was published in February 2021.

The NHS Highland Board submitted a response to the consultation in its own right as well as participating in a joint response from the NHS Highland and The Highland Council Joint Monitoring Committee for Highland and the IJB for Argyll and Bute.

In addition to this, many staff groups and leaders were part of submissions in relation to their field of work. The Scottish Government has received over 1,300 responses to the consultation, the outcome of which is much anticipated.

Financial Performance

The Scottish Government requires NHS Boards to meet three key financial targets:

- a Revenue resource limit;
- a Capital resource limit; and
- a Cash Limit

Further details on non-core elements of expenditure, typically comprising items of a technical accounting nature, can be found in the Summary of Resource Outturn.

	Limit as set by SGHSCD £'000	Actual Outturn £'000	Variance (Deficit)/ Surplus £'000
Core Revenue Resource Limit	904,653	904,198	455
Non-core Revenue Resource Limit	32,815	32,815	0
Total	**937,468**	**937,013**	**455**
Core Capital Resource Limit	64,825	64,825	0
Non-core Capital Resource Limit	16	16	0
Total Capital Resource Limits	**64,841**	**64,841**	**0**
Cash Requirement	1,004,731	1,004,731	0

MEMORANDUM FOR IN YEAR OUTTURN	**£'000**
Core Revenue Resource Variance (Deficit)/Surplus in 2021/2022	455
Financial flexibility: funding banked with/(provided by) Scottish Government	
Underlying (Deficit)/Surplus against Core Revenue Resource Limit	455
Percentage	0%

During 2021/22 the Board was de-escalated from level 4 on the NHS Scotland Governance Framework to level 3.

In order to deliver a balanced financial position in 2021/2022 the NHS Highland needed to generate savings of £32.900m

The Covid 19 pandemic continued to impact on the financial performance of the Board and Scottish Government committed to provide a funding package to ensure delivery of a balanced financial position in 2021/22.

Recognising the need to capture the ongoing financial impact quarterly returns were provided to Scottish Government in an agreed format recording expenditure incurred and forecasting expenditure to the end of the financial year. Funding allocations were made at a number of points throughout the year with a final allocation received in January 2022.

In addition to funding all costs associated with Covid 19, Scottish Government also provided funding to cover slippage on the cost improvement programme. Similar funding packages were put in place nationally to ensure parity across all Boards.

In total, £88.861m was received in respect of Covid 19 funding. This includes funding in respect of Covid 19 costs incurred in 2022/23 which are being managed by Argyll & Bute IJB, Scottish Government and Highland Council.

Savings of £20.463m were achieved in year with 14% of these being delivered recurrently. The balance of the £32.900m cost improvement programme, £12.437m, was funded by Scottish Government as part of the Covid 19 funding package.

A surplus of £0.455m is reported in 2021/22.

The Healing Process is a unique and bespoke offering to aid healing and address harm caused by those who experienced bullying and inappropriate behaviour whilst working for NHS Highland across Highland and Argyll and Bute, in the period to 31 December 2019. This process, which was co-produced with external advisors and whistleblowing and staff-side representatives, opened for registration in late May 2020.

The registration process is now complete and as at 31 March 2022 the Independent Review Panel have recommended outcomes for 270 cases. Total payments of £2.795m, relating to 230 claims, have been approved. Thirteen cases remain to be settled.

Funding has been provided by the Scottish Government to cover the cost of claims awarded and the set up and administration costs. On completion of the process the estimated cost of claims is expected to be in the region of £2.954m. Set up and running costs to date amount to £2.392m. Further costs of administration will be incurred in 2022-23 as the final cases are settled.

Bad debt provision of £1.672m this year (prior year £1.896m) is based on all non-government debt outstanding greater than one year old, except for Road Traffic Accident (RTA) reclaims. Bad debt of 22.43% of total net outstanding value of RTA income has been provided for based on historic patterns of recovery (as per Government guidance). This will change to 23.76% in 22-23.

Public Finance Initiative/Public Private Partnerships

Provision of Easter Ross Primary Care Resource Centre
Start date February 2005 ending January 2030.
This scheme is a redevelopment of County Hospital, Invergordon, into a Primary Care Centre and combines a community hospital and a health centre, integrating primary and community care into one community health resource. There is a 25 year contract with an estimated capital value of £8.8 million and the PFI property will revert to the board at the end of the contract.

Provision of New Craigs Hospital
Start date July 2000 ending June 2025.
This scheme is a replacement for the Craig Dunain Hospital, Inverness, and provides in-Patients' facilities for adults with Mental Health needs or Learning Disabilities. There is a 25 year contract with an estimated capital value of £14.4 million. There are several options available to the board at the end of the contract but no decision has been made yet whether to extend, buy or terminate the agreement.

Provision of Mid Argyll Community Hospital and Integrated Care Centre, Lochgilphead
We financed the development of Mid Argyll Community Hospital and Integrated Care Centre in Lochgilphead by way of a PFI scheme. The period of the contract runs from June 2006 to May 2036 at which point the ownership of the asset will transfer to the board. The estimated capital value of the project is £19.2 million.

Provision of Tain Health Centre
We have a service concession agreement with HUB North of Scotland Ltd for occupancy of the Tain Health Centre effective 24th May 2014. Under the terms of the agreement NHS Highland have a legal commitment to occupy the building for a period of 25 years and will incur annual charges for occupancy, maintenance and running costs. The ownership of the asset will transfer to the Board at the end of the 25 year agreement.

Family Health Services

The programme of patient exemption eligibility checking within the CFS Patient Claims Team (PCT) was suspended in April 2020 due to the COVID-19 pandemic. The PCT were subsequently redeployed to work in the NHS Scotland Test and Protect contact tracing programme. In addition to this, Dental and Ophthalmic services were severely disrupted and restricted for a large part of 2020. As a direct result of this interruption to service provision and combined with the lack of sampled exemption claim cases, there is not sufficient information available to CFS to allow for a robust and meaningful extrapolation calculation to be produced this year. The PCT resumed their programme of work in January 2021 and CFS anticipate that the production of the annual Extrapolation calculation will resume in 2022.

Payment Policy

NHS Highland is committed to supporting the Scottish Government in helping businesses during the current economic situation by paying bills more quickly. The intention is to achieve payment of all undisputed invoices within 10 working days across all public bodies.

The target has been communicated to all non-departmental public bodies, who are working towards the accelerated payment target of 10 working days.

	2020/21	2021/22
Average period of credit taken	12 days	13 days
Percentage of invoices paid within 30 days:		
- by volume	92.10%	93.11%
- by value	94.43%	93.59%
Percentage of invoices paid within 10 days:		
- by volume	76.14%	76.33%
- by value	83.42%	77.19%

The performance of meeting the 10-day target for taking credit has not been met due to reduced priority for the approval process whilst treating COVID patients and with many staff requiring to work at home. However, the volume of invoices which is paid within 30 days has improved.

Pension Liabilities

The accounting policy note for pensions is provided in Note 1 and disclosure of the costs is shown within Note 19 and the remuneration report.

Social Matters

NHS Highland is committed to leading and promoting Equality and Diversity, equal opportunities and supporting human rights in terms of the provision of health services for the community it serves.

NHS Highland has published its Equality Outcomes and Mainstreaming Report in April 2021 which summarises progress towards achieving equality outcomes set in 2017, demonstrates how NHS Highland is working to meet the Public Sector Equality and sets out new outcomes for 2021-2025:

- Outcome 1 - In Highland, people from identified groups, including young people, will have improved access to the resources needed to support their mental health and wellbeing.
- Outcome 2 - In Highland, all individuals are equally safe and respected, and women and girls live free from all forms of violence and abuse and the attitudes that perpetuate it.
- Outcome 3 - In Highland, people from identified groups will have more control over the care and services they receive.

Examples of progress within this report include:

- in consultation with Stonewall, the Scottish Transgender Alliance and Inverness Gender Identity Clinic introduced 'Supporting Transgender Staff in the Workplace - Protocol & Guidance'
- development of the LGBT Diversity Champions Toolkit which provides information and resources aimed at supporting staff to build an inclusive and welcoming environment for LGBT staff, service users/ patients and the wider community
- awarded Carer Positive Award 'established' status

Further details and more information is available within the report published on the NHS Highland website. This includes staff training delivered on equality related issues, employee data, gender pay gap and equal pay statement:

NHS Highland Equality Outcomes and Mainstreaming Report 2021-2025 (scot.nhs.uk)

NHS Highland has put in the place processes to comply with the revised Whistleblowing Standards which were launched with effect from 1 April 2021 and has been liaising closely with the Independent National Whistleblowing Office and our nationally appointed Board Whistleblowing Champion, Albert Donald. We launched our independent, external Speak Up Guardian Service from August 2020, as an additional channel to raise concerns. They are also supporting us with our helpline, confidential contact and our data and reporting for Whistleblowing and have been promoting the service to employees and other relevant parties.

NHS Highland has a zero tolerance for fraud, bribery or corruption. Staff are updated regularly on counter fraud matters including the confidential routes that are available to report suspected fraud, bribery or corruption. A range of fraud awareness initiatives were progressed during the year including targeted awareness in relation to Once for Scotland policies.

NHS Highland has robust procedures in place, which reduce the likelihood of fraud occurring. These are included within the Code of Corporate Governance (i.e Standards of Business Conduct, Standing Orders, Standing Financial Instructions), financial procedures, systems of internal control and risk assessment and not least a comprehensive counter fraud policy action

plan. The Board takes part in a post payment verification system which covers all Family Health Service expenditure.

NHS Highland works closely with other organisations, including Counter Fraud Services (CFS), the Central Legal Office, Audit Scotland, the Cabinet Office, Department for Work and Pensions, the Home Office, Councils, the Police and the Procurator Fiscal/Crown Office to combat fraud and participates in the bi-annual National Fraud Initiative exercise which is a data matching exercise.

Sustainability and Environmental Reporting

The Climate Change (Scotland) Act 2009 originally set out measures adopted by the Scottish Government to reduce emissions in Scotland by at least 80% by 2050. The Climate Change (Emissions Reductions Targets) (Scotland) Act 2019 amended this longer-term target to net-zero by 2045, five years in advance of the rest of the UK. In 2020 'The Climate Change (Scotland) Amendment order came into force to reflect this and now requires NHS Boards to report on their progress in delivering their emissions reduction targets.

All designated Major Players, of which NHS Highland is one, are required to submit an annual report to the Sustainable Scotland Network detailing compliance with the climate change duties imposed by the Act and the Amendment order. The information returned by the Board is compiled into a national analysis report, published annually and superseding the prior requirement for public bodies to publish individual sustainability reports.

Further information on the Scottish Government's approach can be found in the Climate Change Plan 2018-2032 while national reports can be found at the following resource: https://sustainablescotlandnetwork.org/reports

Events after the end of the reporting period
There are no events to report.

Chief Executive and Accountable Officer
5/8/2022

B THE ACCOUNTABILITY REPORT

CORPORATE GOVERNANCE REPORT

(a) The Directors Report

The Directors present their report and the audited financial statements for the year ended 31 March 2022.

Date of Issue
Financial statements were approved by the Board and authorised for issue by the Accountable Officer on 28 June 2022.

Appointment of Auditors
The Public Finance and Accountability (Scotland) Act 2000 places personal responsibility on the Auditor General for Scotland to decide who is to undertake the audit of each health body in Scotland. For the financial years 2016/17 to 2021/22, the Auditor General appointed, Grant Thornton UK LLP, to undertake the audit of NHS Highland. The general duties of the auditors of health bodies, including their statutory duties, are set out in the Code of Audit Practice issued by Audit Scotland and approved by the Auditor General.

Board Membership
Under the terms of the Scottish Health Plan, the Health Board is a board of governance whose membership will be conditioned by the functions of the Board. Members of Health Boards are selected on the basis of their position or the particular expertise which enables them to contribute to the decision-making process at a strategic level.

The Health Board has collective responsibility for the performance of the local NHS system as a whole and reflects the partnership approach, which is essential to improving health and social care.

Chair	Prof. Boyd Robertson	
Executive Directors	Pam Dudek	Chief Executive
	Boyd Peters	Board Medical Director
	Heidi May	Nurse Director
	Tim Allison	Director of Public Health
	Dave Garden	Director of Finance
Non-Executive Directors	Alexander Anderson, Chair Finance, Resources & Performance Committee	
	Graham Bell	
	Jean Boardman	
	James Brander until 27 November 2021	
	Alasdair Christie, Chair Audit Committee	
	Sarah Compton Bishop, Chair Staff Governance Committee	
	Ann Clark, Board Vice Chair, Chair Remuneration Committee and Highland Health and Social Care Committee	
	Albert Donald, nationally appointed Whistleblowing Champion	
	Philip Macrae	
	Joanne McCoy, from 29 November 2021	
	Gerard O'Brien	
	Susan Ringwood	
	Gaener Rodger	
Stakeholder Members	Graham Hardie, Argyll and Bute Council	
	Deirdre Mackay, The Highland Council	
	Margaret Moss, Area Clinical Chair until 6 September 2021	

Catriona Sinclair, Area Clinical Forum Chair from 5 January 2022
Adam Palmer, Employee Director until 30 September 2021
Elspeth Caithness, Employee Director from 1 October 2021

The board members' responsibilities in relation to the accounts are set out in a statement following this report.

The statement of Board Members' responsibilities
Under the National Health Service (Scotland) Act 1978, the Health Board is required to prepare accounts in accordance with the directions of Scottish Ministers which require that those accounts give a true and fair view of the state of affairs of the Health Board as at 31 March 22 and of its operating costs for the year then ended. In preparing these accounts, the Directors are required to:

- apply on a consistent basis the accounting policies and standards approved for the NHS Scotland by Scottish Ministers.
- make judgements and estimates that are reasonable and prudent.
- state where applicable accounting standards as set out in the Financial Reporting Manual have not been followed where the effect of the departure is material.
- prepare the accounts on the going concern basis unless it is inappropriate to presume that the Board will continue to operate.

The Health Board members are responsible for ensuring that proper accounting records are maintained which disclose with reasonable accuracy at any time the financial position of the Board and enable them to ensure that the accounts comply with the National Health Service (Scotland) Act 1978 and the requirements of the Scottish Ministers. They are also responsible for safeguarding the assets of the Board and hence taking reasonable steps for the prevention of fraud and other irregularities.

The NHS Board members confirm they have discharged the above responsibilities during the financial year and in preparing the accounts.

Board members' and senior managers' interests
In line with statutory requirements, the Board maintains a register of Board Members' interests which is available online on our Internet site and is updated annually.

During the year, a number of current Directors/Senior Employees indicated interests in contracts or potential contractors with the Health Board work. These were:

Alexander Anderson	Scrabster Harbour Trust,
Pam Dudek	REDTWO591 LTD
Graham Bell	Director - The Leader Scotland Cove Borough Hall
Jean Boardman	Member of Argyll and Bute Integration Joint Board
James Brander	RSPB
Alasdair Christie	Inverness, Badenoch and Strathspey Citizen's Advice Bureau Highland Councillor
Ann Clark	Elsie Normington Foundation member
Sarah Compton-Bishop	Isle of Jura Development Trust, Jura Care Centre, The Highlands and Islands Transport Partnership (HITRANS)
Albert Donald	Scottish Professional Football League Scottish Football Association NHS Grampian Non-Executive Director, Whistleblowing Champion
Deirdre Mackay	Highland Councillor

	Sutherland Community Partnership East Sutherland & Caithness CAB Voluntary Groups Sutherland
Philip MacRae	Highland Cycle Tours Scottish Social Services Council
Heidi May	University of The Highlands and Islands until December 2021
Joanne McCoy	Highland Third Sector Interface The Reel McCoy, quilting and textiles art
Gerard O'Brien	Voluntary Action Orkney, Trustee THAW Orkney, White Ribbon Scotland
Boyd Peters	Cairngorm Mountain Rescue Team
Susan Ringwood	Cotman Housing Association
Gaener Rodger	Cairngorms National Park Authority Board member Director Kazbeg Ltd Member of Inspiring Young Voices Member Girlguiding Scotland and Girlguiding UK Highland Children's Forum Thriving Families Member of Culloden Academy Parent Council
Catriona Sinclair	Director Spa Pharmacare Ltd. Director Community Pharmacy Scotland, Board member Royal Pharmaceutical Society Scottish Pharmacy Board Director CPS services Edinburgh

All Board Members are Highland Health Board Endowment Fund Trustees

Directors third party indemnity provisions
There have been no third-party indemnity provisions in place for any of the Directors at any time during the year.

Remuneration for non-audit work
Our external auditors, Grant Thornton UK LLP, did not undertake any non-audit work on behalf of the Board.

Value of Land
The value of land (excluding land that has been declared surplus to requirements) recorded in our SoFP is at current value. Surplus land has been valued at Open Market Value.

Public Services Reform (Scotland) Act 2010
Sections 31 and 32 of the Public Services Reform (Scotland) Act 2010 impose new duties on the Scottish Government and listed public bodies to publish information on expenditure and certain other matters as soon as is reasonably practicable after the end of each year. Data is published on our website – Public Services Reform (scot.nhs.uk)

Personal data related incidents reported to the Information Commissioner
During the period 1 April 2021 to 31 March 2022 NHS Highland has reported 4 potential data related incidents or data breaches to the Information Commissioners Office (ICO) with no further action being taken for 3 of these incidents. The ICO is still to report a decision on one incident reported in March 2022. This is an increase from 3 incidents reported to the ICO during the 2020/2021 financial year.

Disclosure of Information to Auditors
The directors who held office at the date of approval of this directors' report confirm that, so far as they are each aware, there is no relevant audit information of which the Board's auditors are unaware; and each director has taken all the steps that they ought reasonably to have taken as

a director to make themselves aware of any relevant audit information and to establish that the Board's auditors are aware of that information.

(b) <u>The statement of the Chief Executive's responsibilities as accountable officer</u>

Under Section 15 of the Public Finance and Accountability (Scotland) Act, 2000, the Principal Accountable Officer (PAO) of the Scottish Government has appointed me as Accountable Officer of NHS Highland.

This designation carries with it, responsibility for:

- the propriety and regularity of financial transactions under my control;
- the economical, efficient and effective use of resources placed at the Board's disposal; and
- safeguarding the assets of the Board.

In preparing the Accounts, I am required to comply with the requirements of the Government's Financial Reporting Manual and, in particular, to:

- observe the accounts direction issued by the Scottish Ministers including the relevant accounting and disclosure requirements and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the Government Financial Reporting Manual have been followed and disclose and explain any material departures; and
- prepare the accounts on a going concern basis.

I confirm that the Annual Report and Accounts as a whole are fair, balanced and reasonable and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that is fair, balanced and understandable.

I am responsible for ensuring proper records are maintained and that the Accounts are prepared under the principles and in the format directed by Scottish Ministers. To the best of my knowledge and belief, I have properly discharged my responsibilities as accountable officer as intimated to me in the Departmental Accountable Officers letter.

(c) The Governance Statement

Scope of Responsibility

As Accountable Officer, I am responsible for maintaining an adequate and effective system of internal control that supports compliance with the organisation's policies and promotes achievement of the organisation's aims and objectives, including those set by Scottish Ministers. Also, I am responsible for safeguarding the public funds and assets assigned to the organisation.

I took responsibility for governance when I was appointed Accountable Officer by Scottish Government on 5 October 2020.

In accordance with IAS 27 – Consolidated and Separate Financial Statements, these Financial Statements consolidate the Highland Health Board Endowments Funds. This statement includes any relevant disclosure in respect of these Endowment Funds Accounts. The external auditors of the Endowment Funds accounts are the firm of accountants, Mackenzie Kerr Ltd.

Purpose of Internal Control

The system of internal control is based on an ongoing process designed to identify, prioritise and manage the principal risks facing the organisation. The system aims to evaluate the nature and extent of risks and to manage risks efficiently, effectively and economically.

The system of internal control is designed to manage rather than eliminate the risk of failure to achieve the organisation's aims and objectives. As such, it can only provide reasonable and not absolute assurance.

The process within the organisation accords with guidance from Scottish Ministers in the Scottish Public Finance Manual (SPFM) and supplementary NHS guidance and has been in place for the year up to the date of approval of the annual report and accounts.

The SPFM is issued by Scottish Ministers to provide guidance to the Scottish Government and other relevant bodies on the proper handling and reporting of public funds. The SPFM sets out the relevant statutory, parliamentary and administrative requirements, emphasises the need for efficiency, effectiveness and economy and promotes good practice and high standards of propriety.

Governance Framework

NHS Highland is responsible for commissioning and providing health care services for the residents of Highland and Argyll and Bute. A Board (the NHS Board), with a majority of Non-Executive members, sets its strategic direction in line with national policy and local needs and, supported by a number of governance committees, receives assurance on achievement of its objectives and on the quality of its services. The Board has collective responsibility for health improvement, the promotion of integrated health and community planning through partnership working, involving the public in the design of healthcare services and staff governance.

The NHS Board's work is closely linked with that of the Argyll and Bute Integration Joint Board which is a separate legal body set up under the Public Bodies (Joint Working) (Scotland) Act 2014 which aims to better integrate Health and Social Care services. The planning, commissioning and oversight of a range of health services and adult social care are delegated by the Board and the Local Authority to the Integration Joint Board.

The Highland Partnership (The Highland Council and NHS Highland) commits to achieving the National Health and Wellbeing Outcomes prescribed by the Scottish Ministers in Regulations under section 5(1) of the Public Bodies (Joint Working) (Scotland) Act 2014 through a Lead Agency arrangement.

Members of Health Boards are selected on the basis of their position, or their particular expertise, which enables them to contribute to the decision-making process at a strategic level.

NHS Highland Board meets every two months to progress its business. All Board meetings are held in public with Board papers and agendas being published on our website. When an item of business is commercially sensitive, that item will be discussed in private session. Public accessibility to Board meetings has been maintained throughout 2021-2022 with access for stakeholders and public through MS Teams.

The Board also holds Development Sessions every two months to discuss topical issues and holds Strategy Sessions in intervening months to consider strategic issues for NHS Highland. The Code of Corporate Governance, which is revised on an annual basis, identifies Committees that report to the Board to help it fulfil its duties. In response to the pandemic during 2021/22, changes were made to the format of governance meetings as detailed in the Covid-19 Pandemic Response section below.

Each Governance Committee has a clear role and remit, is chaired by a Non-Executive Director, with a Non-Executive Vice Chair and at least 2 Non-Executive Director members. All governance committee memberships have been refreshed throughout the year.

The Board's Governance Committees ensuring compliance with relevant laws, regulations and policies and procedures are: Audit Committee; Clinical Governance Committee; Staff Governance Committee; Finance, Resources and Performance Committee; Remuneration Committee; and Pharmacy Practices Committee. All Governance Committee minutes are available to the public on our website. Each Governance Committee submits an annual report to the Audit Committee and the Board confirming that their duties have been carried out in accordance with their prescribed role.

Clinical Governance

Principle Function
To carry out the statutory duties as outlined in NHS MEL(1998~)75, NHS MEL (2000)29 and NHS MEL (2001)74 and to give the Board assurance that clinical and care governance systems are in place and working throughout the organisation

Membership
- 4 Non-Executives Board members, one of whom would Chair the committee
- Chair of the Area Clinical Forum
- Staff side Representative
- 2 Independent Public Members
- Medical Director
- Director of Public Health
- Nurse Director

Chair
Gaener Rodger, Non-Executive Board Director

Frequency of meetings
The Committee meets as necessary to fulfil its purpose but not less than six times a year.

Audit

Principle Function
To provide the Board with the assurance that the activities of NHS Highland Board are within the law and regulations governing the NHS in Scotland that an effective system of internal control is maintained and that a strong corporate governance culture is in operation. The duties of the

Audit Committee are in accordance with the Scottish Government Audit & Assurance Handbook, dated March 2018.

Membership
Five Non-Executive members of NHS Highland Board

Chair
Mr Alasdair Christie, Non-Executive Director

Frequency of meetings
The Committee meets at least 5 time per year, one meeting of which is specifically to consider the annual accounts.

Staff Governance

Principle Function
The purpose of the Staff Governance Committee is to support and maintain a culture within the health system where the delivery of the highest standard possible of staff management is understood to be the responsibility of everyone working within the system, and is built upon partnership and collaboration. It will ensure that robust arrangements to implement the Staff Governance Standard are in place and monitored.

Membership
- Four Non-Executive members
- Employee Director
- Two Area Partnership Forum (Staffside) Representatives
- Chief Executive

Chair
Sarah Compton Bishop, Non-Executive Board Director

Frequency of meetings
The Committee meets as necessary to fulfil its purpose but not less than six times a year.

Remuneration

Principle Function
To consider and agree performance objectives and performance appraisals for staff in the Executive cohort and to oversee performance arrangements for designated senior managers. The Committee will be responsible for applying the remit detailed in NHS: MEL (2000) 25, NHS HDL (2002) 64 and subsequent guidance.

Membership
- Board Chair
- Board Vice Chair
- Employee Director
- 2 Non-Executive Directors

Chair
Ann Clark, Board Vice Chair

Frequency of meetings
The Committee meets as necessary, but not less than three times a year.

Finance, Performance & Resources

Principle Function

Highland Health Board

The purpose of the Committee is to keep under review the financial position and performance against key finance and non-financial targets of the Board, to ensure that suitable arrangements are in place to secure economy, efficiency and effectiveness in the use of all resources and that the arrangements are working effectively.

Membership
- Four Non-Executive members (one of whom will be the Chair).
- Chief Executive
- Director of Finance
- Medical Director
- Director of Public Health
- Director of Nursing

Chair
Alexander Anderson

Frequency of meetings
The Committee meets as necessary to fulfil its remit but not less than six times per year.

Highland Health and Social Care

Principle Function
The purpose is to provide assurance to NHS Highland Board that the planning, resourcing and delivery of those community health and social care services that are its statutory or commissioned responsibility are functioning efficiently and effectively, ensuring that services are integrated so that people receive the care they need at the right time and in the right setting, with a focus on community-based, preventative care

Membership
Voting Committee members as follows
- 5 x Non-Executives, one of whom chairs the Committee and one of whom
- is the Council nominee on the Health Board
- 5 x Executive Directors as follows - Chief Officer, Director of Adult Social
- Care, Finance Lead, Medical Lead and Nurse Lead
- 3 Representatives of Highland Council

The wider stakeholder and advisory membership (non-voting) will be as follows:
- Staff Side Representative (2)
- Public/Patient Member representative (2)
- Carer Representative (1)
- 3rd Sector Representative (1)
- Lead Doctor (GP)
- Medical Practitioner (not a GP)
- 2 representatives from the Area Clinical Forum
- Public Health representative
- Highland Council Executive Chief Officer for Health and Social Care
- Highland Council Chief Social Worker

Chair
Ann Clark, Non-Executive Board Director and Board Vice Chair

Frequency of meetings
The Committee meets at least five times per year

Other Governance Arrangements

NHS Highland's Governance Framework operates under a Code of Corporate Governance which was revised throughout the financial year and approved by the Board in January 2022. The Code includes the following documents:

- NHS Highland Board Committee Structure
- Standing Orders for NHS Highland Board
- Governance Committee Terms of Reference
- Code of Conduct for Board Members
- Standing Financial Instructions
- Reservation of Powers and Scheme of Delegation
- Counter Fraud Policy and Action Plan
- Standards of Business Conduct for Staff

The conduct and proceedings of the NHS Board are set out in the Standing Orders. These specify the matters which are solely reserved for the NHS Board to determine, the matters which are delegated under the scheme of delegation and the matters which are remitted to a Governance Committee of the NHS Board.

All Committees of the Board are required to provide an Annual Statement of Assurance to the Audit Committee and Board, describing their membership, attendance, frequency of meetings, business addressed, outcomes and assurances provided, risk management and to demonstrate they have fully fulfilled their roles and remit. The Board has established an annual self-assessment exercised carried out by Governance Committees in terms of their effectiveness.

Ongoing work to improve Board effectiveness builds on an Improvement Plan originally approved by the Board in 2020 reflecting the requirements of the NHS Scotland Blueprint for Good Governance in terms of DL (2019) 02. An internal audit review was undertaken on the effectiveness of NHS Highland's Board Assurance Framework in May 2021, the outcomes of which were incorporated into an overarching Improvement Plan endorsed by the Board in September 2021. The Internal Audit review confirmed that the key components of the Framework encompass most of the expected areas within the NHS Scotland Blueprint for Good Governance and highlighted improvements to ensure more effective assurance to the Board. In particular, the Board adopted a standard level of assurance approach to its business and incorporated this into the report format for Committees and Board meetings. The following changes are now standard in terms of Board and Committee written reports:

- a clear reference to which strategic objective is being met by the report,
- a more prominent assessment of how the report addresses defined risks, and
- an indication of the 'level of assurance' offered by report writers for papers that are presented for assurance purposes.

Arrangements are being made for an independent assessment of NHS Highland's system of governance against the Blueprint for Good Governance to take place during 2022. Progress against the requirements of the NHS Scotland Blueprint for Good Governance throughout the year is summarised as follows:

Setting Direction

- The Board agreed a one-year Strategy in support of its Remobilisation Plan in March 2021 entitled 'Remobilise, Recover, Redesign: NHS Highland Strategic Direction 2021 – 2022' which set out our vision, values and Board level objectives. In September 2021 the Board gave the go-ahead to the development of a five-year strategic plan to underpin our delivery of Scotland's vision for achieving sustainable, quality health care services. The development of the plan has focussed on active engagement with our population, staff colleagues and partners to secure a shared strategic intent. Since September 2021, the Board has received frequent updates on progress with the development of the Strategy which is now expected to be fully endorsed by the Board in July 2022.

- Annual Committee and Board self-evaluation exercises were initiated in June 2021 through online surveys and workshop sessions. Improvement plans were agreed at both Committee and Board in August 2021. Given the pressures on the organisation in meeting the demands of the pandemic, Governance Committee chairs agreed in November 2021 to undertake a desk-top review of the self-evaluation before the end of the financial year.
- The Board has successfully implemented a co-produced planning cycle framework for the 2021/22 financial year. Workplans were approved by the Board in March 2022 setting out its own business and that of the governance committees for the forthcoming year. Workplans consider all the key plans/strategy documents/annual and other reports required for submission to Scottish Government, with indication of timing/governance committee/executive leads etc. This provides clear oversight of the necessary reporting duties of the Board and ensures appropriate sequencing of Board business. It also takes into account any areas for improvement highlighted in Committee annual self assessments.
- Board and Committee Chairs meetings have taken place throughout the financial year. Potential Committee agenda items are considered and scheduled as appropriate. The Group maintains oversight of Governance Committee remits and priorities.
- Weekly meetings are held between the Chief Executive, Chair and Vice Chair.
- The Board's delivery of its Culture Programme is a standing item at Staff Governance Committee, Board meetings and has been discussed at many Development Sessions.

Assessing Risk

Risk Management is a key element of the Board's internal controls for Corporate Governance. NHS Highland's Audit Committee provides assurance to the Board that risk management arrangements are in place and risks are managed effectively.

The Board has developed and an interim strategy and policy for Risk Management.

- Executive Directors Group reviewed the risk appetite and tolerance 23 August 2021
- In September 2021 the Board agreed a proposal to revise risk appetite and tolerance. The Risk Strategy and Policy will be updated to incorporate the risk appetite and tolerance and will be completed by the summer of 2022. Thereafter a communication plan will be developed to ensure that staff are informed of the approach being taken. Risk management training will be revised and delivered at different level across the Board.

The Strategic Risks are reviewed by the responsible Executive Director on a bi-monthly basis and is presented to the NHS Highland Board at each of its meetings.

The Executive Directors Group is responsible for reviewing the strategic risk register and agreeing new risks for inclusion onto the strategic risk register.

Skills, Experience and Diversity

- The Board's local orientation and induction programme for Board members remains under review and has adapted to comply with the restrictions associated with the Covid19 pandemic. An adapted induction programme making full use of MSTeams was used for new Non-Executive member inductions in December 2021 and January 2022.
- NHS Highland Non-Executive Board members now have access to Turas Learn materials and 4 Non-Executive Board members have joined the National Mentoring Scheme.
- We established a buddying system between Non-Executive and Executive Board members with effect from June 2021 as an opportunity to share knowledge and experience and to enhance relationships. This has been supplemented with Non-Executive members joining in 'virtual visits' in support of our strategy engagement and exploring the outcomes of NHS Highland's Listening and Learning staff survey as part of our Culture development.
- Board members undertook training provided by NHS Education for Scotland in April 2021 looking specifically at Active Governance.
- Independent expertise was co-opted to strengthen our Audit Committee for a one year period with effect from 1 April 2021. This arrangement has proven very successful with an experienced individual having made significant contribution to the work of the Audit Committee throughout the financial year. With the consent of Scottish Government, the Board

agreed on 29 March 2022 to suspend its Standing Orders to extend this arrangement for a further period of two years with effect from 1 April 2022. This decision was made in acknowledgement that the course of action was unique to this co-option arrangement and that the rationale to override the national direction set out in the Audit and Assurance Handbook of 2018 was supported by Scottish Government.

Roles, Responsibilities and Accountabilities

- NHS Highland's Executive Directors Group and System Leadership Team creates an empowered and accountable system of leadership. The leadership structure functions in an agile, decisive and connected way across our health and care system to ensure the right outcomes for the people of North Highland and Argyll and Bute and has adapted throughout the financial year to address the pressures on the system associated with dealing with the pandemic.
- There have been changes to NHS Highland Board membership during the financial year: a new Employee Director appointed in October 2021, a new Non-Executive Board member appointed in November 2021 and a new Area Clinical Forum Chair appointed in January 2022.
- The Board refreshed its Committee memberships in January 2022 to maximise the skills and abilities of its members and to take into account the needs of newer Board members.
- NHS Highland reviewed its Governance Committees' Terms of Reference during September 2021 with agreed documents being endorsed by the Audit Committee in December 2021 and incorporated into a refreshed Code of Corporate Governance approved by the Board in January 2022.

Other Governance Arrangements

The development needs of Executive and Non-Executive Directors are identified through a process of regular appraisal. New Non-Executive Directors receive an induction which forms part of training for all Board members. Regular development sessions are held to address the needs of Non-Executive Directors.

Performance is a key element of the structure at all levels with programmes of work under a Performance Recovery Board and a Financial Recovery Board. These programme Boards are driven by the strategic direction and operational delivery requirements and are accountable to the Finance, Resources and Performance Committee of the Board.

NHS Highland has introduced a bi-monthly Integrated Quality and Performance report, visible throughout the leadership structure as a high-level overview of the performance of our system of health and care. Reporting on aspects of Clinical, Operational, Financial and Staff governance, the report ensures a holistic view of the organisation which is governed through the Board's Governance Committees.

The Board's Remobilisation Plan Version 4 was approved by the Board in September 2021 and reviewed in January 2022. The Remobilisation Plan submitted to Scottish Government reflects the anticipated recovery of the health and care system through until April 2022. The Plan focuses on the areas agreed as priorities with the Scottish Government and includes information on 15 workstreams and associated projects to improve patient care and to transform services to ensure they are fit for purpose in the new context the NHS finds itself in. The Integrated Performance and Quality Report takes a cross system view of performance and has a particular focus on the Remobilisation Plan targets, reflecting the performance of NHS Highland in the context of remobilisation and the ongoing presence of COVID19. Our Remobilisation Plan has been agreed with the Scottish Government Health and Social Care Directorate.

The component parts of the Remobilisation Plan are monitored regularly through the Highland Health & Social Care Committee and the Argyll & Bute Integration Joint Board, which provide assurance to the Board that the operational units are on track to deliver the key objectives.

In May 2021 NHS Highland received confirmation that a revision to the Integration Scheme for the Argyll and Bute IJB had been signed off by the Cabinet Secretary for Health and Sport. The Scheme must be reviewed each subsequent period of 5 years beginning with the day on which the Scheme is approved, in the case of Argyll and Bute Health and Social Care Partnership this began on 27 June 2015. The statutory responsibility to review the Scheme sits with NHS Highland Board and Argyll and Bute Council.

The NHS Highland Board appoints four of its members to the IJB who are therefore able to provide assurance to the Board regarding the IJB's overall performance and financial position. The NHS Highland Board also receives a copy of the IJB performance report as per its production frequency to consider as part of its Board business schedule. The financial position relating to health services provided in Argyll & Bute is reported to each meeting of NHS Highland Board within the Integrated Quality and Performance report. The overall financial position of the IJB is reported to each IJB meeting.

Other forms of assurance flow through the operational management structure, with the IJB's Chief Officer being jointly accountable to the Board's Chief Executive and the Council's Chief Executive. The IJB's Chief Finance Officer has a professional link to the Board's Director of Finance and there is a regular dialogue regarding the financial position.

The Board seeks to promote good governance throughout its joint working with a wide range of organisations: Local Authorities, Third Sector and other organisations both within and external to the NHS, in particular through the Highland and Argyll and Bute Community Planning Partnerships.

Culture

During 2021/22, NHS Highland has continued with a strong focus on improving culture as part of our transformation agenda. We have continued in addressing the findings of the Sturrock review, published in May 2019, and to date have delivered 31 out of the 35 actions arising from the recommendations from the report, despite the impact of the pandemic which for our Board has been more significant in the latter parts of this year than in previous periods. The 4 remaining actions are also progressing.

Our Culture Oversight Group has continued to meet throughout the year, reporting to Staff Governance Committee and overseeing progress with our Culture programme and plans, with representation from colleagues, partnership, leadership and leaders, as well as specialist areas. We have implemented a refreshed Culture programme dashboard and assurance report, which is presented every two months to the Staff Governance Committee and NHS Highland Board. This ensures progress is clearly visible and well scrutinised at all levels of the organisation.

A number of key deliverables have progressed in this year. In the summer, we launched our Culture Amp platform and surveyed colleagues experience across the Board area with our bespoke Listening and Learning survey. We developed and launched our 4 level Leadership and Management development programme, with the first cohorts of 72 colleagues starting this in October 2021.

We've continued to work with our Independent Speak Up Guardian service, who worked with 193 colleagues in their first year to July 2021, and a further 205 from August 2021 to March 2022. This is an essential part of understanding our colleagues experiences, offering alternative routes for listening and being able to resolve issues and rebuilt trust and confidence.

We have invested significantly in our People Function, rolling out a people partner model, reshaping our People Services function, investing in workforce planning and data and analytics capability, as well as creating a new Talent function, with a dedicated Organisational Development team.

Our partnership work on our People Processes and the implementation of the Once for Scotland policies has started to show real progress with dealing effectively with cases of Bullying and Harassment and particularly the critical role of early resolution. In the last 12 months 35 cases were raised (39 last year), and of those 30 attempted early resolution with 14 were resolved at this stage and 10 are still at this stage with 6 progressing to investigation and formal process. So early resolution has resolved the situation in 40% of all cases raised, and a further 33% of cases are still in this process. This is a major step forward in avoiding long and complex investigations which are harmful for all involved.

The Whistleblowing Standards have been implemented across NHS Scotland in April 2021, and NHS Highland has been leading the way in embracing the benefits of the standards and promoting them across the organisation and wider in scope colleagues providing services. Our work has been supported by our Non-Executive Director Whistleblowing Champion who has been proactively visiting sites across the Board area and feeding back to management on areas of concern that are raised. We commissioned an Internal Audit review of the implementation and the minor recommendations have now been implemented, but the commitment in embedding the standards was noted.

We've also continued to deliver our bespoke and unique Healing Process across the year, with the process expecting to close by July 2022, with the final cases being heard by our Remuneration Committee and a final report to the Board. The Remuneration Committee heard 180 cases over this year, with 271 people having been through the process when it concludes and 117 apologies from the Chief Executive and 230 people accessing Psychological Therapies. We've received three Organisational Learning reports to date from the Independent Review Panel, which have been reported to the Board and actions taken to address the findings which are also being tracked. We commissioned an Internal Audit into the process earlier this year, which reported positively on the process and the care taken to ensure confidentiality and oversight, with some minor recommendations which have been implemented

Improving engagement is a key element of our Culture transformation and over the year we've held virtual coffee breaks and Ask Me Anything Q&A sessions with Executives and recorded Video updates from the Chief Executive, as well as weekly round ups. We've had extensive engagement on our culture and on the development of our Together We care strategy with colleagues and the public, in person and online and we've just commissioned our new website design, to improve access to information for colleagues and the wider community.

Finally, Wellbeing has been an important area for us in 2021/2, with investment in resource and tactical wellbeing actions being promoted to provide immediate support to our colleagues who were experiencing the toughest time in their working lives to date. Our Wellbeing strategy and plan is being developed alongside our overarching strategy, our culture ambitions and our workforce strategy and plan to ensure that we have a long term, sustainable view on how best to support our colleagues to support our patients and communities.

As we move into 2022/3, in addition to the Wellbeing agenda, we will be focussing on rolling out our Team Conversations initiative, which will be piloted in the coming months, helping teams to come together and to agree their ways of working aligned to our NHS Scotland values.

We're developing an ambitious plan, working with Vanderbilt and Jerry Hickson, to embed a model of Promoting Professionalism across NHS Highland, based on the Civility saves lives principles, to ensure our patients and colleagues are treated with kindness, dignity and respect and concerns can be raised and addressed by peers, quickly and locally.

Our other key area of focus will be on implementing a consistent appraisal and personal development planning experience across the Board, this is a long term piece of work, but one that is critical to achieve.

Level 3 Escalation

In April 2021 NHS Highland was de-escalated from Stage 4 to Stage 3 on the Scottish Government Framework. The escalation status continues to apply with support and scrutiny focussing on the following areas:

- Finance
- Governance, Leadership & Culture
- Mental Health performance

Level 3 reflects significant variation from plan; risks materialising and with tailored support required for a formal recovery plan agreed with Scottish Government. Throughout the financial year NHS Highland has worked closely with Scottish Government,

A Financial Recovery Board informs the Board of progress and risks via the Finance, Resources and Performance Committee. The membership comprises the Executive Team, Senior Responsible Officers and clinical leaders.

NHS Highland's unique and fully embedded Programme Management Office has supported the Board through a range of interventions and assistance to provide support, capacity and expertise in the financial recovery process. NHS Highland now has in-house skills to provide the best practice assurance function for delivery of the cost improvement programme, planning and delivery of cost improvement schemes, effective problem solving and risk management, robust project and programme management approaches as well as skills and competencies.

NHS Highland submitted to Scottish Government its 4th Remobilisation Plan in September 2021 with updates as required by Scottish Government. These documents summarise our work in several key areas of activity.

Covid19 Pandemic Response

NHS Highland continued to face unprecedented pressure as it responded to the Covid-19 Pandemic throughout the financial year. The Board has held meetings exclusively through virtual means, assessed and adapted its governance framework within the financial year to accommodate the pressures on the system.

The Board introduced a number of temporary governance arrangements and then reinstated its full governance framework within the first year of the Covid19 pandemic. At the beginning of the financial year the Board agreed to continue with full governance arrangements but was mindful of the load and the backlog on the Executive. At that time, it was noted that agenda items may not always require full written reports and that verbal updates may be more appropriate in some cases.

Responding to Scottish Government's encouragement to keep governance arrangements under review, the Board agreed in November 2021 to pause development sessions and to restrict business at Board and Committee meetings to the most essential elements. The Board reviewed this position in March 2022 and agreed to extend this approach throughout the remainder of the financial year, with a further review in May 2022. Meetings therefore continued to be held on MS Teams. The operation of the Audit and Remuneration Committees was excluded from this decision, thereby ensuring compliance with the UK Corporate Governance Code and the Scottish Public Finance Manual. The Gold, Silver and Bronze Command structure was stood down in March 2021 with flexibility to step up again as necessary. The following governance arrangements were therefore maintained by the Board and in effect throughout the financial year 2021-22:

- Board meetings held bi-monthly (with public observer attendance possible through MS Teams technology) with regular updates on Covid19 and any pressing governance matters brought forward from the Chairs' Group.
- Bi-monthly meetings of the Chairs' Group with the Chief Exec (and members of the Exec Team as necessary)

- Weekly Meetings of Chair and Chief Executive
- Weekly meetings of Chair, Vice Chair, Chief Executive and Deputy Chief Executive and Chair of Argyll and Bute IJB

Annual self assessments for Committees were established in 2020. Given the continuing pressure in responding to the Covid-19 pandemic, Committee Chairs and Lead Executives carried out a desk exercise to assess progress against the previous year's self-evaluation feedback rather than repeating the process in 2021.

Information Governance and Security

Responsibility for oversight of information governance within NHS Highland falls on the Information Assurance Group. The group meets on a 2 monthly schedule and is chaired by the Interim Deputy Chief Executive/SIRO who also represents information governance and information security at board level. The composition of the Information Assurance Group membership ensures that Information Governance, information security and data protection matters are considered from diverse organisational viewpoints.

Being classified as an operator of essential service, NHS Highland is subject to the Network and Information Systems (NIS) regulations. Compliance to the NIS regulations is monitored by the Scottish Health Competent Authority who conduct annual audit assessments against the Scottish Public Sector Cyber Resilience Framework control set. The 2021 NIS audit resulted in a compliance score of 51% which was broadly in line with other NHS Scotland Boards and indicated several areas of improvement. A Digital Resilience Group chaired by the NHS Highland Head of Resilience has been created to act as a focal point for improving cyber security, resilience, and NIS compliance across NHS Highland. NHS Highland have become early adopters of the NSS provisioned Cyber Centre of Excellence, a specialist cyber security function that strengthens NHS Highlands ability to detect, respond and recover from cyber incidents.

Risk Management

NHS Highland is subject to the requirements of the SPFM and has complied with them, where relevant and applicable to NHS bodies. As part of these requirements, it must operate a risk management strategy in accordance with relevant guidance issued by Scottish Ministers. The general principles for a successful risk management strategy are set out in the SPFM.

NHS Highland, like all organisations, faces a wide range of risks at all levels strategically and operationally. NHS Highland recognises that healthcare provision and the activities associated with caring for patients, employing staff, providing facilities and managing finances are all, by their nature, activities that involve areas of uncertainty or "risk". Risk management is the framework within which NHS Highland manages these uncertainties and is one of the internal controls used to meet its corporate governance responsibilities. Effective risk management is the systematic application of principles and processes to identify, assess, evaluate and control risks to both the objectives of NHS Highland and to core service delivery and processes.

Oversight of the NHS Highland risk management framework is through the Risk Management Steering Group, which is a subcommittee of the Audit Committee. It oversees the strategic / corporate risks of the Board, ensuring that a risk register is maintained and updated regularly, and that action is taken to mitigate risks identified.

Development sessions have been held in 2021-22 with the Executive Directors Group and the Board. The board strategic risk register has been developed so that each risk is owned by an Executive Director and is aligned to a Governance Committee for assurance and scrutiny. All Governance Committees have received a report on the relevant risks included in the Board risk register (level 1), along with associated operational risks for discussion. Work has begun on realigning existing operational risk registers (Level 2 and 3) to the new organisational structure.

The Risk Management Policy was revised in line with the methodology in March 2021 and will be reviewed and updated in 2022.

Development of the risk management as outlined above has increased Governance Committees' awareness and knowledge of their revised responsibilities around risk management. Training has been carried out and further training at executive and operational levels will be required to ensure the entirety of NHS Highland is working to embed and improve risk management, in line with the changes to the risk management policy. Oversight of ongoing improvements is through an internal audit on risk management in 2021 which has generated 12 recommendations. Progress is reported through risk management steering group up to the audit committee. as part of the improvement work, a corporate risk manager post is currently going to advert. This new post will support the further embedding of robust risk management systems and practise within NHS Highland.

Review of Adequacy and Effectiveness

As Accountable Officer, I am responsible for reviewing the adequacy and effectiveness of the system of internal control. My review is informed by:

- Executive and senior managers who are responsible for developing, implementing and maintaining internal controls across their areas;
- the work of the internal auditors, who submit to the Audit Committee regular reports which include their independent and objective opinion on the effectiveness of risk management, control and governance processes, together with recommendations for improvement; and
- comments by the external auditors in their management letters and other reports.

The Audit Committee meets regularly throughout the year with the specific remit to review and give assurances on the system of internal control. The Committee agrees the internal audit plan, considers the internal audit reports, reviews recommendations and ensures actions are undertaken that result from these reports.

Internal Audit reviews identify agreed actions to be undertaken. These are subsequently followed up to ensure these actions have happened within the timescales agreed. The Executive Directors Group has been reviewing these on an ongoing basis and where previously agreed dates have slipped for the higher risk actions, ensuring that these are completed by the revised agreed dates. The Audit Committee continues to monitor and receive reports on progress to completion of all the actions and has taken active and positive steps to improve implementation of Internal Audit recommendations.

The Audit Committee has reported to the Board regularly and highlighted key issues throughout the year.

Conclusion

No other significant control weaknesses or issues have arisen during the previous financial year and no significant failures have arisen in the expected standard for good governance, risk management and control.

I am able to conclude that taking account of the above statement and the assurances received from the Board's Committees that corporate governance was operating effectively throughout the financial year to 31st March 2022.

REMUNERATION REPORT AND STAFF REPORT

Board members' and senior employees' remuneration

Board Members and Senior Employee Remuneration is subject to ministerial direction and the arrangements for payment are covered by Health Department instruction (currently PCS (ESM) 2019/01).

The implementation of these instructions is monitored by the Remuneration Sub Committee, whose membership is:

Prof. Boyd Robertson, Board Chair
Ann Clark, Remuneration Committee Chair and Board Vice Chair
Adam Palmer, Employee Director (until 30 September 2021)
Elspeth Caithness, Employee Director (from 1 October 2021)
Gerry O'Brien, Non-Executive Director (from 25 January 2022)
Bert Donald, Non-Executive Director (from 25 January 2022)

Performance Related Pay has not been processed at the year end for 2021/22.

Performance is assessed through a standardised performance management process which measures achievement against objectives.

All Non-Executive Directors are appointed by the Scottish Government Ministers for a fixed term. All other Senior Managers are on permanent contracts with the exception of David Park, Deputy Chief Executive and Louise Bussell, Chief Officer Highland Health and Social Care Partnership, who are appointed on an interim basis.

Highland Health Board

Remuneration Report for the year ended 31 March 2022 (audited)						
	Note	Gross Salary (Bands of £5,000)	Benefits in Kind (£'000 to nearest £100)	Total Earnings in Year (Bands of £5,000)	Pension benefits (£'000)	Total Remuneration (Bands of £5,000)
Executive Members						
Chief Executive: Pam Dudek		145-150	6.3	150-155	112	265-270
Nursing Director: Heidi May		110-115		110-115	38	150-155
Medical Director: Boyd Peters		170-175		170-175	94	265-270
Director of Finance: David Garden		100-105		100-105	43	145-150
Director of Public Health & Health Policy: Tim Allison		135-140		135-140	33	165-170
Non Executive Members						
The Chair: Prof Boyd Robertson		25-30		25-30		25-30
Adam Palmer - until 30 September 2021	a	40-45		40-45	4	45-50
Gaener Rodger		10-15		10-15		10-15
Sarah Compton-Bishop		10-15		10-15		10-15
James Brander - until 27 November 2021	b	5-10		5-10		5-10
Alasdair Christie		10-15		10-15		10-15
Deirdre Mackay		5-10		5-10		5-10
Pamela Clark (known as Ann)		15-20		15-20		15-20
Jean Boardman		5-10		5-10		5-10
Alexander Anderson		10-15		10-15		10-15
(Al)Bert Donald		5-10		5-10		5-10
Philip Macrae		5-10		5-10		5-10
Margaret Moss - until 6 September 2021.	c	35-40		35-40	90	125-130
Graham Hardie		5-10		5-10		5-10
Gerard O'Brien		5-10		5-10		5-10
Graham Bell		5-10		5-10		5-10
Susan Ringwood		5-10		5-10		5-10
Joanne McCoy - appointed 29 November 2021	d	0-5		0-5		0-5
Elspeth Caithness - appointed to the Board 1 October	e	40-45		40-45	8	45-50
Catriona Sinclair - Appointed 5 January 2022	f	0-5		0-5		0-5
Senior Employees						
Chief Officer: Louise Bussell		100-105		100-105	27	125-130
Director of Human Resources: Fiona Hogg		110-115		110-115	29	140-145
Director of Strategic Commissioning, Planning & Performan		125-130		125-130	35	160-165
Deputy Chief Officer: David Park		125-130		125-130	34	160-165
Chief Operating Officer Acute: Katherine Sutton		105-110		105-110	48	155-160
Director of Estates: Alan Wilson		95-100		95-100	60	155-160
Fiona Davies - Chief officer IJB appointed 1/5/21	g	95-100	2.8	100-105	65	165-170
George Morrison - IJB Acting Chief officer 1/4/21-3/5/21, Depiuty Chief officer 1/7/21-9/8/21	h	85-90		85-90	46	135-140
Notes						
The value of pension benefits accrued during the year is calculated as: the real increase in pension multiplied by 20 plus the real increase in any lump sum less the contributions made by the individual						
a. The gross salary for Adam Palmer includes salary in the range of 35-40 for full time employee director role						
b. The gross salary for James Brander is for the period shown, the full year effect salary is in the range of 5-10						
c. The gross salary for Margaret Moss as Area Clinical Forum Chair for period shown and includes her full time role as Lead AHP, the full year effect is in the salary range 45-50.						
d. The gross salary for Joanne McCoy Non Executive Director is for period shown, the full year effect is 5-10						
e The gross salary for Elspeth Caithness includes full time salary in range 35-40 for Employee director role. The full year effrect of salary is in range 45-50						
f. The gross salary for Catriona Sinclair Area Clinical Forum Chair, the full year effect salary is in the range of 5-10						
g. The gross salary for Fiona Davies Chief officer IJB is for period shown, the full year effect is in the salary range 100-105						
h. George Morrison - IJB Acting Chief officer 1/4/21-3/5/21, Deputy Chief officer 1/7/21-9/8/21						
Non executive directors pay is non pensionable						

Highland Health Board

Remuneration Report for the year ended 31 March 2022 (audited)	Accrued pension at pensionable age as at 31 Mar 22 (bands of £5,000)	Total accrued lump sum at pensionable age (bands of £5,000)	Real increase in pension at pensionable age (bands of £2,500)	Real increase in lump sum at pensionable age (bands of £2,500)	Cash Equivalent Transfer Value (CETV) at 31 Mar 22 £000	Cash Equivalent Transfer Value (CETV) at 31 Mar 21 £000	Real increase in CETV in year £000
Executive Members							
Chief Executive: Pam Dudek	50-55	110-115	5-7.5	7.5-10	1,044	910	133
Nursing Director: Heidi May	25-30	40-45	2.5-5	0-2.5	491	441	49
Medical Director: Boyd Peters	65-70	160-165	5-7.5	5-7.5	1,442	1,315	127
Director of Finance: David Garden	35-40	65-70	2.5-5	0-2.5	664	609	55
Director of Public Health & Health Policy: Tim Allison	0-5	n/a	2.5-5	n/a	61	25	37
Non Executive Members							
The Chair: Prof Boyd Robertson							
Adam Palmer - until 30 September 2021	15-20	50-55	0-2.5	0-2.5	442	425	17
Gaener Rodger							
Sarah Compton-Bishop							
James Brander - until 27 November 2021							
Alasdair Christie							
Deirdre Mackay							
Pamela Clark (known as Ann)							
Jean Boardman							
Alexander Anderson							
(Al)Bert Donald							
Philip Macrae							
Margaret Moss - until 6 September 2021.	30-35	90-95	2.5-5	7.5-10	754	646	108
Graham Hardie							
Gerard O'Brien							
Graham Bell							
Susan Ringwood							
Joanne McCoy - appointed 29 November 2021							
Elspeth Caithness - appointed to the Board 1 October	15-20	45-50	0-2.5	0-2.5	351	334	17
Catriona Sinclair - Appointed 5 January 2022							
Senior Employees							
Chief Officer: Louise Bussell	0-5	n/a	0-2.5	n/a	41	16	25
Director of Human Resources: Fiona Hogg	5-10	n/a	0-2.5	n/a	64	39	26
Director of Strategic Commissioning, Planning & Perf	55-60	120-125	2.5-5	n/a	1,201	1,136	65
Deputy Chief Officer: David Park	10-15	n/a	2.5-5	n/a	163	126	37
Chief Operating Officer Acute: Katherine Sutton	40-45	90-95	2.5-5	0-2.5	855	789	66
Director of Estates: Alan Wilson	35-40	n/a	2.5-5	n/a	502	446	56
Fiona Davies - Chief officer IJB appointed 1/5/21	20-25	55-60	2.5-5	5-7.5	412	352	60
George Morrison - IJB Acting Chief officer 1/4/21-3/5/21, Depiuty Chief officer 1/7/21-9/8/21	45-50	125-130	2.5-5	2.5-5	1,071	1,000	72

Highland Health Board

Remuneration Report for the year ended 31 March 2021 (audited)						
	Note	Gross Salary (Bands of £5,000)	Benefits in Kind (£'000)	Total Earnings in Year (Bands of £5,000)	Pension benefits (£'000)	Total Remuneration (Bands of £5,000)
Executive Members						
Chief Executive: Pam Dudek - commenced 5/10/20 (was seconded as Deputy Chief exec from 20/04/2020)	a	70-75	0	70-75	210	280-285
Interim Chief Executive: Paul Hawkins - left 4/10/20 but continued to mentor Chief Exec until 31/1/21	b	115-120	0	115-120	n/a	115-120
Director of Finance: David Garden		100-105	0	100-105	44	140-145
Medical Director: Boyd Peters		175-180		175-180	18	195-200
Nursing Director: Heidi May	c	110-115		110-115	39	150-155
Director of Public Health & Health Policy: Tim Allison - commenced 01/07/2020	d	95-100	0	95-100	23	120-125
Non Executive Members						
The Chair: Prof Boyd Robertson		35-40	0	35-40		35-40
Graham Bell - commenced 01/01/2021		0-5	0	0-5		0-5
Alexander Anderson		10-15	0	10-15		10-15
Jean Boardman		5-10	0	5-10		5-10
James Brander		5-10	0	5-10		5-10
Alasdair Christie		10-15	0	10-15		10-15
Sarah Compton-Bishop		10-15	0	10-15		10-15
Ann (Pamela) Clark		15-20	0	15-20		15-20
(Al)bert Donald		5-10	0	5-10		5-10
Graham Hardie - commenced 24/09/2020		0-5	0	0-5		0-5
Alasdair Lawton - until 31/05/2020		0-5	0	0-5		0-5
Deirdre MacKay		5-10	0	5-10		5-10
Philip Macrae		5-10	0	5-10		5-10
Margaret Moss	e	70-75	0	70-75	28	150-155
Gerard O'Brien - commenced 01/01/2021		0-5	0	0-5		0-5
Adam Palmer	f	45-50	0	45-50	17	65-70
Ann Pascoe - until 15/07/2020		0-5	0	0-5		0-5
Susan Ringwood - commenced 01/01/2021		0-5	0	0-5		0-5
Gaener Rodger		10-15	0	10-15		10-15
Senior Employees						
Chief Officer: Louise Bussell - commenced 09/11/2020		30-35	0	30-35	17	50-55
Board Secretary: Ruth Daly		50-55	0	50-55	15	65-70
Director of Human Resources: Fiona Hogg		105-110	0	105-110	26	130-135
Director of Strategic Commissioning, Planning & Performance: Deb Jones		125-130	0	125-130	40	160-165
Director of Public Relations & Engagement: Jane McGirk - left 31/10/2020		85-90	0	85-90	12	95-100
Deputy Chief Officer: David Park		125-130	0	125-130	32	155-160
Chief Operating Officer Acute: Katherine Sutton		105-110	0	105-110	101	205-210
Director of Estates: Alan Wilson - commenced 30/11/2020		30-35	0	30-35	111	140-145
Notes						
The value of pension benefits accrued during the year is calculated as: the real increase in pension multiplied by 20 plus the real increase in any lump sum less the contributions made by the individual						
a The gross salary for Pamela Dudek is for the period shown, the full year effect salary is in the range of 135-140						
b Paul Hawkins is an employee of Fife Health Board and his salary is recharged to Highland Health Board, the disclosure above is for the period shown, the full year effect salary is in the range of 135-140						
c Nurse Director temporary responsibility bonus relating to Covid included for Heidi May. Per circular PCS(ESM)2021/2						
d The gross salary for Tim Allison is for the period shown, the full year effect salary is in the range of 110-115						
e The gross salary for Margaret Moss includes salary in the range of 60-65 for her full time role as Lead AHP						
f The gross salary for Adam Palmer includes salary in the range of 35-40 for full time employee director role						

Highland Health Board

Remuneration Report for the year ended 31 March 2021 (audited)							
	Accrued pension at pensionable age as at 31 Mar 21 (bands of £5,000)	Total accrued lump sum at pensionable age (bands of £5,000)	Real increase in pension at pensionable age (bands of £2,500)	Real increase in lump sum at pensionable age (bands of £2,500)	Cash Equivalent Transfer Value (CETV) at 31 Mar 21 £000	Cash Equivalent Transfer Value (CETV) at 31 Mar 20 £000	Real increase in CETV in year £000
Executive Members							
Chief Executive: Pam Dudek - commenced 5/10/20 (was seconded as Deputy Chief exec from 20/04/2020)	45-50	100-105	7.5-10	20-22.5	918	708	211
Interim Chief Executive: Paul Hawkins - left 4/10/20 but continued to mentor Chief Exec until 31/1/21	50-55	155-160	(2.5)-0	(2.5)-0	1191	1,170	21
Director of Finance: David Garden	30-35	65-70	2.5-5	0-2.5	614	560	54
Medical Director: Boyd Peters	60-65	150-155	0-2.5	0-(2.5)	1,275	1,225	51
Nursing Director: Heidi May	20-25	45-50	2.5-5	0-2.5	456	407	49
Director of Public Health & Health Policy: Tim Allison - commenced 01/07/2020	0-5	0	0-2.5	0	24	0	24
Non Executive Members							
The Chair: Prof Boyd Robertson							
Graham Bell - commenced 01/01/2021							
Alexander Anderson							
Jean Boardman							
James Brander							
Alasdair Christie							
Sarah Compton-Bishop							
Ann (Pamela) Clark							
(Al)bert Donald							
Graham Hardie - commenced 24/09/2020							
Alasdair Lawton - until 31/05/2020							
Deirdre MacKay							
Philip Macrae							
Margaret Moss	25-30	75-80	0-2.5	0-2.5	626	584	42
Gerard O'Brien - commenced 01/01/2021							
Adam Palmer	15-20	50-55	0-2.5	2.5-5	403	372	31
Ann Pascoe - until 15/07/2020							
Susan Ringwood - commenced 01/01/2021							
Gaener Rodger							
Senior Employees							
Chief Officer: Louise Bussell - commenced 09/11/2020	0-5	0	0-2.5	0	15	0	15
Board Secretary: Ruth Daly	0-5	N/A	0-2.5	N/A	57	44	13
Director of Human Resources: Fiona Hogg	0-5	n/a	0-2.5	n/a	36	14	22
Director of Strategic Commissioning, Planning & Performance: Deb Jones	55-60	120-125	2.5-5	0-2.5	1,133	1,067	66
Director of Public Relations & Engagement: Jane McGirk - left 31/10/2020	0-5	n/a	0-2.5	n/a	35	23	12
Deputy Chief Officer: David Park	5-10	n/a	0-2.5	n/a	119	87	32
Chief Operating Officer Acute: Katherine Sutton	40-45	90-95	5-7.5	7.5-10	790	677	113
Director of Estates: Alan Wilson - commenced 30/11/2020	30-35	35-40	5-7.5	5-7.5	439	358	81

Highland Health Board

Fair Pay disclosure (Subject to Audit)

Subject to Audit	2022 (£000's)		2021 (£000's)		% Change
Range of staff remuneration	5,000-300,000		5,000-300,000		0
Highest earning Director's total remuneration (£000s)	173		175		-1.14%
Median (total pay & benefits)	33		31		6.45%
Median (salary only)	33		31		6.45%
Ratio	5.28		5.69		-7.21%
25th Percentile (total pay & benefits)	26		25		4.00%
26th Percentile (salary only)	26		25		4.00%
Ratio	6.70		7.11		-5.77%
75th Percentile Pay (total pay & benefits)	42		41		2.44%
76th Percentile Pay (salary only)	42		41		2.44%
Ratio	4.09		4.34		-5.76%

The increase in the percentiles is due to nationally agreed pay awards, including incremental rises in 21/22. The ratios have decreased due to reduced level of highest paid director's total remuneration.

For part time employees the total pay for calculation of the median is grossed up.

Contracts of less than 2 hours were removed, as this led to very high annual salaries when grossed up and distorted the median result.

Agency staff are excluded, as they are not employees and are charged via invoice, not via payroll.

Number of senior staff by band

Employees whose remuneration fell within the following ranges:

	2022	2021
Clinicians	**Number of Staff**	**Number of Staff**
£70,001 - £80,000	74	68
£80,001 - £90,000	59	57
£90,001 - £100,000	48	52
£100,001 - £110,000	48	44
£110,001 - £120,000	45	48
£120,001 - £130,000	39	29
£130,001 - £140,000	30	27
£140,001 - £150,000	21	19
£150,001 - £160,000	25	22
£160,001 - £170,000	16	14
£170,001 - £180,000	14	9
£180,001 - £190,000	5	8
£190,001 - £200,000	2	2
£200,001 and above	10	10

Highland Health Board

	2022	2021
Other	**Number of Staff**	**Number of Staff**
£70,001 - £80,000	14	14
£80,001 - £90,000	14	13
£90,001 - £100,000	7	4
£100,001 -£110,000	4	5
£110,001 - £120,000	3	1
£120,001 - £130,000	2	2
£130,001 - £140,000	0	0
£140,001 - £150,000	1	0
£150,001 - £160,000	0	0
£160,001 - £170,000	0	0
£170,001 - £180,000	0	0
£180,001 - £190,000	0	0
£190,001 - £200,000	0	0
£200,001 and above	0	0

STAFF NUMBERS AND COSTS (audited)

	Executive Board Members £000	Non Executive Members £000	Permanent Staff £000	Inward Secondees £000	Other Staff £000	Outward Secondees £000	2022 Total £000	2021 Total £000
STAFF COSTS								
Salaries and wages	673	190	363,175	0	0	(1,438)	**362,600**	**356,512**
Social security costs	87	6	35,906	0	0	(166)	**35,833**	**33,222**
NHS scheme employers' costs	135	0	65,839	0	0	(240)	**65,734**	**60,963**
Other employers pension costs	0	0	5,607	0	0	0	**5,607**	**0**
Inward secondees	0	0	0	415	0	0	**415**	**350**
Agency staff	0	0	0	0	20,551	0	**20,551**	**16,201**
TOTAL	**895**	**196**	**470,527**	**415**	**20,551**	**(1,844)**	**490,740**	**467,248**

	2022	2021
Employee expenditure as above	490,740	467,248
Employee income included in Note 4 and IAS19 costs excluded from above (note 19)	1,844	1,263
Total employee expenditure disclosed in note 3	492,584	468,511

THC Pension fund costs have been reclassified to staff costs in 2022, shown under other employers pension costs above. Prior year comparative has not been adjusted as not material.

STAFF NUMBERS (audited)

	Executive Board Members	Non Executive Members	Permanent Staff	Inward Secondees	Other Staff	Outward Secondees	2022 Total	2021 Total
Whole time equivalent (WTE)	5	17	9,141	8	45*	(37)	**9,179**	**8,896**
Included in the total staff numbers above were disabled staff of:							**111**	**111**

*other staff includes medical locums for which there is no WTE calculation.

STAFF COMPOSITION (information not subject to audit)

Staff composition – an analysis of the number of persons of each sex who were directors and employees

	2021			2022		
	Male	**Female**	**Total**	**Male**	**Female**	**Total**
Executive Directors	3	2	5	3	2	5
Non Executive Directors and Employee Director	10	7	17	8	9	17
Senior Employees	3	5	8	3	5	8
Other	2,528	13,460	15,988	2,674	14,081	16,755
Total Headcount	**2,544**	**13,474**	**16,018**	**2,688**	**14,097**	**16,785**

SICKNESS ABSENCE (information not subject to audit)

	2021	2022
Sickness Absence Rate	4.7%	5.3%

EMPLOYMENT OF DISABLED PERSONS (information not subject to audit)

Staff policies applied during the financial year relating to the employment of disabled persons.

1. For giving full and fair consideration to applications for employment by the Board made by disabled persons, having a regard to their particular aptitudes and abilities;

   NHS Highland continues to operate a Job Interview Guarantee (JIG), which means that if an applicant has a disability and meets the minimum criteria outlined within the person specification, they will be guaranteed an interview. However, some disabled applicants prefer not to take this option, so they have an option on our application form to indicate whether they wish to participate in this scheme or not.

   NHS Highland was awarded Disability Confident Status in November 2016 and is working towards the 'Leader' status. This scheme replaces the previous 2 ticks scheme;

2. For continuing the employment of, and for arranging appropriate training for, employees of the Board who have become disabled persons during the period when they were employed by the Board;

   NHS Highland's policy for the Management of Capability is utilised to support staff to continue in employment should their health condition affect their ability to perform their existing role.

   Reasonable adjustments, where possible are considered to support staff to maintain their employment and this is reviewed on a regular basis by the Manager with Occupational Health, HR and other relevant support such as Access to Work.

   In the event that a reasonable adjustment cannot be made, alternative suitable employment via the utilisation of NHS Highland's Redeployment Policy is considered to allow continuation of employment.

3. Otherwise for the training, career development and promotion of disabled persons employed by the Board;

   All staff have a responsibility for Equality and Diversity for themselves, colleagues and/or patients/clients. As part of NHS Highland's responsibility to mainstream equalities, NHS Highland works to ensure employees with protected characteristics are not discriminated upon and are treated with dignity, respect and due regard for their needs as employees. Our aspiration is to be a Great Place to work and our board level objective of Being inclusive means we will ensure colleagues feel valued and engaged as well as treated with dignity and respect.

OUTCOME	PROTECTED CHARACTERISTIC
Continue to work as a Stonewall Diversity Champion to promote LGBT equality in the workplace	Sexual Orientation
Achieve Disability Confident Leader Status	Disability
Increase the number of staff completing equalities monitoring forms	All
Achieve exemplary status in the Carer Positive Award	All

Ensure completion of the Equality and Human Rights training module by all colleagues	All

EXIT PACKAGES – current year – (audited)

	2022			
Exit package cost band	**Number of compulsory redundancies**	**Number of other departures agreed**	**Total number of exit packages by cost band**	**Cost of exit packages (£000)**
<£10,000				
£10,000 - £25,000		1	1	11
£25,000 - £50,000				
£50,000 - £100,000				
Total number of exit packages by type		**1**	**1**	
Total resource cost (£000)		**11**		**11**

EXIT PACKAGES – prior year	2021			
Exit package cost band	**Number of compulsory redundancies**	**Number of other departures agreed**	**Total number of exit packages by cost band**	**Cost of exit packages (£000)**
<£10,000				
£10,000 - £25,000		2	2	30
£25,000 - £50,000				
£50,000 - £100,000				
Total number of exit packages by type		**2**	**2**	
Total resource cost (£000)		**30**		**30**

TRADE UNION DISCLOSURE – information not subject to audit

The Trade Union (Facility Time Publication Requirements) Regulations 2017 came into force on 1 April 2017. The regulations place a legislative requirement on relevant public sector employers to collate and publish, on an annual basis, a range of data on the amount and cost of facility time within their organisation. The table below details the necessary statutory disclosure data in terms for those that were employed to undertake trade union duties in fiscal year to March 2021.

Number of employees who were relevant union officials during the fiscal year to March 2021	11
WTE employee number	6.05
Percentage of time	**Number of Representatives**
0%	
1-50%	5
51%-99%	
100%	6
	£000
Total Cost of facility time	243.8
Total Pay Bill	492,584
Percentage Pay Bill on facility time and union duties	49.48%

PARLIAMENTARY ACCOUNTABILITY REPORT – Subject to Audit

Losses and Special Payments

On occasion, the Board is required to write off balances which are no longer recoverable. Losses and special payments require formal approval to regularise such transactions and their notation in the annual accounts.

The write-off of the following losses and special payments has been approved by the board:

	No. of cases	**£000**
Losses	507	3,557

There was one claim individually greater than £300,000 settled under the CNORIS scheme in 2021/22 and one in 2020/21. Further details on the scheme can be found in note 1 (accounting policies) of the annual accounts.

The Board is also required to provide for CNORIS claims notified to it and which will be settled at a future date; details of these provisions can be found in note 13.

Signed:

Chief Executive and Accountable Officer.

5/8/2022

Independent auditor's report to the members of Highland NHS Board, the Auditor General for Scotland and the Scottish Parliament

Reporting on the audit of the financial statements

Opinion on financial statements
We have audited the financial statements in the annual report and accounts of Highland NHS Board and its group for the year ended 31 March 2022 under the National Health Service (Scotland) Act 1978. The financial statements comprise the Statement of Consolidated Comprehensive Net Expenditure, the Consolidated and Board Statement of Financial Position, the Statement of Consolidated Cashflows, the Statement of Consolidated Changes in Taxpayers' Equity and notes to the accounts, including significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and UK adopted international accounting standards, as interpreted and adapted by the 2021/22 Government Financial Reporting Manual (the 2021/22 FReM).

In our opinion the accompanying financial statements:

- give a true and fair view in accordance with the National Health Service (Scotland) Act 1978 and directions made thereunder by the Scottish Ministers of the state of the affairs of the board and its group as at 31 March 2022 and of the net expenditure for the year then ended;
- have been properly prepared in accordance with UK adopted international accounting standards, as interpreted and adapted by the 2021/22 FReM; and
- have been prepared in accordance with the requirements of the National Health Service (Scotland) Act 1978 and directions made thereunder by the Scottish Ministers.

Basis for opinion

We conducted our audit in accordance with applicable law and International Standards on Auditing (UK) (ISAs (UK)), as required by the Code of Audit Practice approved by the Auditor General for Scotland. Our responsibilities under those standards are further described in the auditor's responsibilities for the audit of the financial statements section of our report. We were appointed by the Auditor General on 31 May 2016. The period of total uninterrupted appointment is six years. We are independent of the board and its group in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK including the Financial Reporting Council's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. Non-audit services prohibited by the Ethical Standard were not provided to the board. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern basis of accounting

We have concluded that the use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the ability of the board and its group to continue to adopt the going concern basis of accounting for a period of at least twelve months from when the financial statements are authorised for issue.

These conclusions are not intended to, nor do they, provide assurance on the board's current or future financial sustainability. However, we report on the board's arrangements for financial sustainability in a separate Annual Audit Report available from the Audit Scotland website.

Risks of material misstatement

We report in our Annual Audit Report the most significant assessed risks of material misstatement that we identified and our judgements thereon.

Responsibilities of the Accountable Officer for the financial statements

As explained more fully in the Statement of the Chief Executive's Responsibilities as the Accountable Officer, the Accountable Officer is responsible for the preparation of financial statements that give a true and fair view in accordance with the financial reporting framework, and for such internal control as the Accountable Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accountable Officer is responsible for assessing the ability of the board and its group to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless there is an intention to discontinue the board's operations.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the decisions of users taken on the basis of these financial statements.

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities outlined above to detect material misstatements in respect of irregularities, including fraud. Procedures include:

- Obtaining an understanding of the applicable legal and regulatory frameworks and identifying which laws and regulations are significant in the context of the board
- Obtaining an understanding of how the board is complying with that framework. We enquired of management, internal audit and the chair of the Audit and Risk Committee, whether they were aware of any instances of non-compliance with laws and regulations or whether they had any knowledge of actual, suspected, or alleged fraud.

We enquired of management and the Audit and Risk Committee concerning the board and group's policies and procedures relating to:

- the identification, evaluation and compliance with laws and regulations;
- the detection and response to the risks of fraud; and
- the establishment of internal controls to mitigate risks related to fraud or non-compliance with laws and regulations.

Assessing the susceptibility of the financial statements to material misstatement, including how fraud might occur, evaluating management's incentives and opportunities for manipulation of the financial statements. This included the evaluation of the risk of management override of controls and any other fraud risks identified for the audit. We determined that the principal risks were in relation to manual journals, including year-end journals, accounting estimates in relation to the valuation of land and buildings, overstatement of other income and understatement of expenditure.

Our audit procedures involved:

- evaluation of the design effectiveness of controls that management has in place to prevent and detect fraud;
- journal entry testing, with a focus on manual year-end journals**;**
- challenging assumptions and judgements made by management in its significant accounting estimates in respect of land and building valuations**;**
- sample testing the occurrence and accuracy of other income and the completeness of expenditure; and
- assessing the extent of compliance with the relevant laws and regulations as part of our procedures on the related financial statement item.

- Considering whether the audit team collectively has the appropriate competence and capabilities to identify or recognise non-compliance with laws and regulations. This included consideration of the engagement team's:
  - understanding of, and practical experience with, audit engagements of a similar nature and complexity through appropriate training and participation
  - knowledge of the health sector and economy in which the board and group operates
  - understanding of the legal and regulatory requirements specific to the board and group including:
    - the provisions of the applicable legislation
    - rules and related guidance issued by Scottish Government
    - the applicable statutory provisions.
- The team communications in respect of potential non-compliance with relevant laws and regulations, including the potential for fraud in revenue and expenditure recognition and the significant accounting estimates related to land and building valuations.

In assessing the potential risks of material misstatement, we obtained an understanding of:

- The board and group’s operations, including the nature of its income and expenditure and its services and of its objectives and strategies to understand the classes of transactions, account balances, financial statement consolidation processes, expected financial statement disclosures and business risks that may result in risks of material misstatement.
- The board and group’s control environment, including the policies and procedures implemented by the board and group to ensure compliance with the requirements of the financial reporting framework.

The extent to which our procedures are capable of detecting irregularities, including fraud, is affected by the inherent difficulty in detecting irregularities, the effectiveness of the board’s controls, and the nature, timing and extent of the audit procedures performed. These audit procedures were designed to provide reasonable assurance that the financial statements were free from fraud or error. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error and detecting irregularities that result from fraud is inherently more difficult than detecting those that result from error, as fraud may involve collusion, deliberate concealment, forgery or intentional misrepresentations. Also, the further removed non-compliance with laws and regulations is from events and transactions reflected in the financial statements, the less likely we would become aware of it.

Irregularities that result from fraud are inherently more difficult to detect than irregularities that result from error as fraud may involve collusion, intentional omissions, misrepresentations, or the override of internal control. The capability of the audit to detect fraud and other irregularities depends on factors such as the skilfulness of the perpetrator, the frequency and extent of

manipulation, the degree of collusion involved, the relative size of individual amounts manipulated, and the seniority of those individuals involved.

A further description of the auditor's responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Reporting on regularity of expenditure and income

Opinion on regularity

In our opinion in all material respects the expenditure and income in the financial statements were incurred or applied in accordance with any applicable enactments and guidance issued by the Scottish Ministers.

Responsibilities for regularity

The Accountable Officer is responsible for ensuring the regularity of expenditure and income. In addition to our responsibilities in respect of irregularities explained in the audit of the financial statements section of our report, we are responsible for expressing an opinion on the regularity of expenditure and income in accordance with the Public Finance and Accountability (Scotland) Act 2000.

Reporting on other requirements

Opinion prescribed by the Auditor General for Scotland on the audited part of the Remuneration Report and Staff Report

We have audited the parts of the Remuneration Report and Staff Report described as audited. In our opinion, the audited part of the Remuneration Report and Staff Report has been properly prepared in accordance with the National Health Service (Scotland) Act 1978 and directions made thereunder by the Scottish Ministers.

Other information

The Accountable Officer is responsible for other information in the annual report and accounts. The other information comprises the Performance Report and the Accountability Report excluding the audited part of the Remuneration Report and Staff Report.

Our responsibility is to read all the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the course of the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether this gives rise to a material misstatement in the financial statements themselves. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact. We have nothing to report in this regard.

Our opinion on the financial statements does not cover the other information and we do not express any form of assurance conclusion thereon except on the Performance Report and Governance Statement to the extent explicitly stated in the following opinions prescribed by the Auditor General for Scotland.

Opinions prescribed by the Auditor General for Scotland on the Performance Report and Governance Statement

In our opinion, based on the work undertaken in the course of the audit:

- the information given in the Performance Report for the financial year for which the financial statements are prepared is consistent with the financial statements and that report has been prepared in accordance with the National Health Service (Scotland) Act 1978 and directions made thereunder by the Scottish Ministers; and
- the information given in the Governance Statement for the financial year for which the financial statements are prepared is consistent with the financial statements and that report has been prepared in accordance with the National Health Service (Scotland) Act 1978 and directions made thereunder by the Scottish Ministers.

Matters on which we are required to report by exception

We are required by the Auditor General for Scotland to report to you if, in our opinion:

- adequate accounting records have not been kept; or
- the financial statements and the audited part of the Remuneration Report and Staff Report are not in agreement with the accounting records; or
- we have not received all the information and explanations we require for our audit; or
- there has been a failure to achieve a prescribed financial objective.

We have nothing to report in respect of these matters.

Conclusions on wider scope responsibilities

In addition to our responsibilities for the annual report and accounts, our conclusions on the wider scope responsibilities specified in the Code of Audit Practice are set out in our Annual Audit Report.

Use of our report

This report is made solely to the parties to whom it is addressed in accordance with the Public Finance and Accountability (Scotland) Act 2000 and for no other purpose. In accordance with paragraph 120 of the Code of Audit Practice, we do not undertake to have responsibilities to members or officers, in their individual capacities, or to third parties.

Joanne Brown

Joanne Brown (for and on behalf of Grant Thornton UK LLP),
110 Queen Street
Glasgow
G1 3BX
Date: 9/8/2022

CONSOLIDATED STATEMENT OF COMPREHENSIVE NET EXPENDITURE
for the year ended 31 March 2022

2021 £000		Note	2022 £000
468,510	Staff Costs	3a	492,584
	Other operating expenditure	3b	
106,343	Independent Primary Care Services		111,321
138,890	Drug and medical supplies		154,052
611,145	Other health care expenditure		645,956
1,324,888	Gross expenditure for the year		**1,403,913**
(400,711)	Less: operating income	4	(428,305)
(3,293)	Associates and joint venture accounted for on an equity basis	24a	(7,332)
920,884	**Net Expenditure for the year**		**968,276**

OTHER COMPREHENSIVE NET EXPENDITURE

2021 £000			
2,380	Net (gain)/loss on revaluation of property, plant and equipment		(23,430)
12,598	Actuarial Change in Local Government Pension	19	(10,674)
14,978	**Other comprehensive expenditure**		**(34,104)**
935,862	**Comprehensive net expenditure**		**934,172**

The Notes to the Accounts, numbered 1 to 26, form an integral part of these Accounts.

Highland Health Board

CONSOLIDATED and BOARD STATEMENT OF FINANCIAL POSITION as at 31 March 2022

Consolidated 2021 £000	Board 2021 £000		Note	Consolidated 2022 £000	Board 2022 £000
		Non-current assets:			
396,751	396,751	Property, plant and equipment	7	461,718	461,718
1,743	1,743	Intangible assets	6	1,736	1,736
		Financial assets:			
8,497	106	Investments	10	8,696	102
3,293		Investments in associated and joint ventures		10,625	0
11,300	11,300	Trade and other receivables	9	26,978	26,978
421,584	**409,900**	**Total non-current assets**		**509,753**	**490,534**
		Current Assets:			
6,406	6,406	Inventories	8	7,236	7,236
0	0	Intangible assets	6	0	0
		Financial assets:			
52,628	52,724	Trade and other receivables	9	45,377	45,488
971	88	Cash and cash equivalents	11	935	15
60,005	**59,218**	**Total current assets**		**53,548**	**52,739**
481,589	**469,118**	**Total assets**		**563,301**	**543,273**
		Current liabilities:			
(22,496)	(22,496)	Provisions	13a	(14,595)	(14,595)
		Financial liabilities:			
(136,430)	(136,414)	Trade and other payables	12	(149,214)	(149,195)
(158,926)	**(158,910)**	**Total current liabilities**		**(163,809)**	**(163,790)**
322,663	**310,208**	**Non-current assets plus/less net current assets/liabilities**		**399,492**	**379,483**
		Non-current liabilities			
(38,351)	(38,351)	Provisions	13a	(45,428)	(45,428)
		Financial liabilities:			
(32,484)	(32,484)	Trade and other payables	12	(27,731)	(27,731)
(70,835)	**(70,835)**	**Total non-current liabilities**		**(73,159)**	**(73,159)**
251,828	**239,373**	**Assets Less liabilities**		**326,332**	**306,323**
		Taxpayers' Equity			
116,048	116,048	General fund	SoCTE	145,438	145,438
97,455	97,455	Revaluation reserve	SoCTE	118,734	118,734
25,870	25,870	Other reserves	SoCTE	42,151	42,151
3,293	0	Other reserves – associated and joint ventures	SoCTE	10,625	0
9,162	0	Fund held on trust	SoCTE	9,384	0
251,828	**239,373**	**Total taxpayers' equity**		**326,332**	**306,323**

The Notes to the Accounts, numbered 1 to 26, form an integral part of these Accounts.

The financial statements were approved by the Board on 28th June 2022 and signed on their behalf by:

5/8/2022

…….. Director of Finance

5/8/2022

…….. Chief Executive and Accountable Officer

Highland Health Board

STATEMENT OF CONSOLIDATED CASH FLOWS
for the year ended 31 March 2022

2021 £000		Note	2022 £000	2022 £000
	Cash flows from operating activities			
(920,884)	Net operating cost	SoCTE	(968,276)	
11,541	Adjustments for non-cash transactions	2b	30,223	
2,787	Add back: interest payable recognised in net operating cost	2b	2,465	
(30)	Deduct: interest receivable recognised in net operating cost	4	(11)	
54,157	Movements in working capital	2b	(8,932)	
(852,429)	**Net cash outflow from operating activities**	26c		**(944,531)**
	Cash flows from investing activities			
(54,984)	Purchase of property, plant and equipment		(54,879)	
(396)	Purchase of intangible assets		(672)	
(561)	Investment Additions	10	(119)	
0	Transfer of assets to other NHS Scotland bodies		0	
108	Proceeds of disposal of property, plant and equipment		139	
403	Receipts from sale of investments		174	
30	Interest received		11	
(55,400)	**Net cash outflow from investing activities**	26c		**(55,346)**
	Cash flows from financing activities			
912,692	Funding		1,004,819	
(935)	Movement in general fund working capital	SoCTE	(88)	
911,757	Cash drawn down	SoCTE	**1,004,731**	
(2,180)	Capital element of payments in respect of finance leases and on-balance sheet PFI contracts	2b	(2,425)	
(454)	Interest paid		(333)	
(2,333)	Interest element of finance leases and on-balance sheet PFI/PPP contracts	2b	(2,132)	
906,790	**Net Financing**	26c		**999,841**
(1,039)	**Net Increase/(decrease) in cash and cash equivalents in the period**			(36)
2,010	**Cash and cash equivalents at the beginning of the period**			971
971	**Cash and cash equivalents at the end of the period**			**935**
	Reconciliation of net cash flow to movement in net debt/cash			
(1,039)	Increase/(decrease) in cash in year			(36)
2,010	Net debt at 1 April			971
971	**Net cash at 31 March**			**935**

The Notes to the Accounts, numbered 1 to 26, form an integral part of these Accounts.

Highland Health Board

CONSOLIDATED STATEMENT OF CHANGES IN TAXPAYERS' EQUITY
for the year ended 31 March 2022

	Note	General Fund	Revaluation Reserve	Other Reserve	Other Reserve – associated with joint ventures	Funds Held on Trust	Total Reserves
		£000	£000	£000	£000	£000	£000
Balance at 31 March 2021		116,048	97,455	25,870	3,293	9,162	251,828
Changes in taxpayers' equity for 2021/22							
Net (loss) on revaluation/indexation of property, plant and equipment	7a		23,430				23,430
Net gain/(loss) on revaluation of investments	10					257	257
Impairment of property, plant and equipment			(6,523)				(6,523)
Revaluation & impairments taken to operating costs	2b		6,523				6,523
Transfers between reserves		2,151	(2,151)				0
Other non cash costs (Asset Transfer) (THC ASC Pension)		(2,007)		16,281			14,274
Net operating cost for the year	CFS	(975,573)			7,332	(35)	(968,276)
Total recognised income and expense for 2021/22		(975,429)	21,279	16,281	7,332	222	(930,315)
Funding:							
Drawn down	CFS	1,004,731					1,004,731
Movement in General Fund (Creditor)	CFS	88					88
Balance at 31 March 2022	SoFP	**145,438**	**118,734**	**42,151**	**10,625**	**9,384**	**326,332**

The Notes to the Accounts, numbered 1 to 26, form an integral part of these Accounts.

CONSOLIDATED STATEMENT OF CHANGES IN TAXPAYERS' EQUITY – PRIOR YEAR

	Note	General Fund	Revaluation Reserve	Other Reserve	Other Reserve – associated with joint ventures	Funds Held on Trust	Total Reserves
		£000	£000	£000	£000	£000	£000
Balance at 31 March 2020		**116,891**	**102,194**	**35,205**	**0**	**7,822**	**262,112**
Changes in taxpayers' equity for 2020/21							
Net gain on revaluation / indexation of property, plant and equipment	7a	0	(2,380)	0	0	0	(2,380)
Net gain on revaluation of available for sale financial assets	10	0	0	0	0	1,091	1,091
Impairment of property, plant and equipment			(12)	0	0	0	(12)
Revaluation & impairments taken to operating costs	2a	0	12	0	0	0	12
Transfers between reserves		2,359	(2,359)	0	0	0	0
Other non cash costs (movement in year ASC pension costs)		8,532	0	(9,335)	0	0	(803)
Net operating cost for the year	CFS	(924,426)	0	0	3,293	249	(920,884)
Total recognised income and expense for 2020/21		(913,535)	(4,739)	(9,335)	3,293	1,340	(922,976)
Funding:							
Drawn down	CFS	911,757	0	0	0	0	911,757
Movement in General Fund (Creditor)	CFS	935	0	0	0	0	935
Balance at 31 March 2021	SoFP	**116,048**	**97,455**	**25,870**	**3,293**	**9,162**	**251,828**

The Notes to the Accounts, numbered 1 to 26, form an integral part of these Accounts.

ACCOUNTING POLICIES

1. Authority

In accordance with the accounts direction issued by Scottish Ministers under section 19(4) of the Public Finance and Accountability (Scotland) Act 2000 appended, these Accounts have been prepared in accordance with the Government Financial Reporting Manual (FReM) issued by HM Treasury, which follows International Financial Reporting Standards as adopted by the United Kingdom, IFRIC Interpretations and the Companies Act 2006 to the extent that they are meaningful and appropriate to the public sector. They have been applied consistently in dealing with items considered material in relation to the accounts.

The preparation of financial statements in conformity with IFRS requires the use of certain critical accounting estimates. It also requires management to exercise its judgement in the process of applying the accounting policies. The areas involving a higher degree of judgement or complexity or areas where assumptions and estimates are significant to the financial statements are disclosed in section 29 below.

(a) Standards, amendments and interpretations effective in the current year.

There are no new standards, amendments or interpretations effective in the current year.

b) Standards, amendments and interpretation early adopted this year

There are no new standards, amendments or interpretations early adopted this year.

c) Standards, amendments and interpretation issued but not adopted this year

IFRS 16 Leases supersedes IAS 17 Leases and is being applied by HM Treasury in the Government Financial Reporting Manual (FReM) from 1 April 2022. IFRS 16 introduces a single lessee accounting model that results in a more faithful representation of a lessee's assets and liabilities and provides enhanced disclosures to improve transparency of reporting on capital employed. Under IFRS 16, lessees are required to recognise assets and liabilities for leases with a term of more than 12 months, unless the underlying asset is of low value. While no standard definition of 'low value' has been mandated, NHS Scotland have elected to utilise the capitalisation threshold of £5,000 to determine the assets to be disclosed. NHS Highland expects that its existing finance leases will continue to be classified as leases. All existing operating leases will fall within the scope of IFRS 16 under the 'grandfathering' rules mandated in the FReM for the initial transition to IFRS 16. In future years, new contracts and contract renegotiations will be reviewed for consideration under IFRS 16 as implicitly identified right-of-use assets. Assets recognised under IFRS 16 will be held on the Statement of Financial Position as (i) right of-use assets which represent the Board's right to use the underlying leased assets; and (ii) lease liabilities which represent the obligation to make lease payments.

The bringing of leased assets onto the Statement of Financial Position will require depreciation and interest to be charged on the right-of-use asset and lease liability, respectively. Cash repayments will also be recognised in the Statement of Cash Flows, as required by IAS 7.

The Board has assessed the impact that the application of IFRS 16 would have on the comprehensive net expenditure for the financial year ending 31 March 2023 and on the Statement of Financial position at that date. The figures below are based on the opening position of existing leases as at 31 March 2022.

The standard is expected to increase total expenditure in 2022-23 by £1.773 million. Right-of-use assets totalling £87.249 million will be brought onto the Statement of Financial position, with an associated liability of £87.249 million.

2. Basis of Consolidation

In accordance with IFRS 10 – Consolidated Financial Statements, the Financial Statements consolidate Highland Health Board Endowment Funds.

NHS Endowment Funds were established by the NHS (Scotland) Act 1978. The legal framework under which charities operate in Scotland is the Charities and Trustee Investment (Scotland) Act 2005. Under the 1978 Act Endowment, Trustees are also members of the NHS Board. The Board members (who are also Trustees) are appointed by Scottish Ministers.

The Highland Health Board Endowment Funds is a Registered Charity with the Office of the Charity Regulator (OSCR) and is required to prepare and submit Audited Financial Statements to OSCR on an annual basis.

The basis of consolidation used is Merger Accounting. Any intragroup transactions between the Board and the Endowment Fund have been eliminated on consolidation.

The integration of health and social care services under the terms of the Public Bodies (Joint Working) (Scotland) Act 2014 and associated secondary legislation impacts on Health Board disclosure requirements in the annual accounts.

In accordance with IAS 28 – Investments in Associates and Joint Arrangements, the primary financial statements have been amended for the additional disclosure required to accurately reflect the interest of IJBs using the equity method of accounting.

Note 24 to the Annual Accounts, details how these consolidated Financial Statements have been calculated.

3. Retrospective restatements

There are no retrospective restatements to disclose.

4. Going Concern

The accounts are prepared on the going concern basis, which provides that the entity will continue in operational existence for the foreseeable future.

5. Accounting Convention

The Accounts are prepared on a historical cost basis, as modified by the revaluation of property, plant and equipment, intangible assets, inventories, available-for-sale financial assets and financial assets and liabilities (including derivative instruments) at fair value. Fair value is defined as the amount for which an asset could be exchanged between knowledgeable, willing parties in an arms-length transaction.

6. Funding and Revenue Recognition

Most of the expenditure of the Health Board as Commissioner is met from funds advanced by the Scottish Government within an approved revenue resource limit. Cash drawn down to fund expenditure within this approved revenue resource limit is credited to the general fund.

All other income receivable by the board that is not classed as funding is recognised in the year in which it is receivable.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met and is measured as the sums due under the sale contract.

Non-discretionary funding out with the RRL is allocated to match actual expenditure incurred for the provision of specific pharmaceutical, dental or ophthalmic services identified by the Scottish Government. Non-discretionary expenditure is disclosed in the accounts and deducted from operating costs charged against the RRL in the Statement of Resource Outturn (SoRO).

Funding for the acquisition of capital assets received from the Scottish Government is credited to the general fund when cash is drawn down.

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in the Consolidated Statement of Comprehensive Net Expenditure (SOCNE) except where it results in the creation of a non-current asset such as property, plant and equipment in which case it is recognised in the Statement of Consolidated Financial Position.

7. Property, plant and equipment

The treatment of capital assets in the accounts (capitalisation, valuation, depreciation, particulars concerning donated assets) is in accordance with the NHS Capital Accounting Manual.

Title to properties included in the accounts is held by Scottish Ministers.

7.1 Recognition

Property, Plant and Equipment is capitalised where: it is held for use in delivering services or for administrative purposes; it is probable that future economic benefits will flow to, or service potential be provided to, the Board; it is expected to be used for more than one financial year; and the cost of the item can be measured reliably.

All assets falling into the following categories are capitalised:

1) Property, plant and equipment assets which are capable of being used for a period which could exceed one year and have a cost equal to, or greater than, £5,000.
2) In cases where a new hospital would face an exceptional write off of items of equipment costing individually less than £5,000, the Board has the option to capitalise initial revenue equipment costs with a standard life of 10 years.
3) Assets of lesser value may be capitalised where they form part of a group of similar assets purchased at approximately the same time and cost over £20,000 in total or where they are part of the initial costs of equipping a new development and total over £20,000.

7.2 Measurement

Valuation:

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

All assets that are not held for their service potential (i.e. investment properties and assets held for sale), including operational assets which are surplus to requirements where there are no restrictions on disposal which would prevent access to the market, are measured subsequently at fair value as follows:

Specialised NHS Land, buildings, equipment, installations and fittings are stated at depreciated replacement cost, as a proxy for fair value as specified in the FReM.

Non specialised land and buildings, such as offices, are stated at fair value.

Valuations of all land and building assets are reassessed by valuers under a 5-year programme of professional valuations and adjusted in intervening years to take account of movements in prices since the latest valuation. The valuations are carried out in accordance with the Royal Institution of Chartered Surveyors (RICS) Appraisal and Valuation Manual insofar as these terms are consistent with the agreed requirements of the Scottish Government.

Non-specialised equipment, installations and fittings are valued at fair value. Boards value such assets using the most appropriate valuation methodology available (for example, appropriate indices). A depreciated historical cost basis is a proxy for fair value in respect of such assets which have short useful lives or low values (or both).

Assets under construction are valued at current cost. This is calculated by the expenditure incurred to which an appropriate index is applied to arrive at current value. These are also subject to impairment review.

To meet the underlying objectives established by the Scottish Government, the following accepted variations of the RICS Appraisal and Valuation Manual have been required:

Specialised operational assets are valued on a modified replacement cost basis to take account of modern substitute building materials and locality factors only.

Operational assets which are in use delivering front line services or back office functions and surplus assets with restrictions on their disposal are valued at current value in existing use. Assets have been assessed as surplus where there is no clear plan to bring the asset back into future use as an operational asset.

Temporary decreases in asset values or impairments are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to the Statement of Comprehensive Net Expenditure.

Subsequent expenditure:

Subsequent expenditure is capitalised into an asset's carrying value when it is probable the future economic benefits associated with the item will flow to the Board and the cost can be measured reliably. Where subsequent expenditure does not meet these criteria, the expenditure is charged to the SoCCNE. If part of an asset is replaced, then the part it replaces is de-recognised, regardless of whether or not it has been depreciated separately.

Revaluations and Impairment:

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse an impairment previously recognised in the SoCCNE, in which case they are recognised as income. Movements on revaluation are considered for individual assets rather than groups or land/buildings together.

Permanent decreases in asset values and impairments are charged gross to the SoCCNE. Any related balance on the revaluation reserve is transferred to the General Fund.

Gains and losses on revaluation are reported in the SoCCNE.

7.3 Depreciation

Items of Property, Plant and Equipment are depreciated to their estimated residual value over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

Depreciation is charged on each main class of tangible asset as follows:

1) Freehold land is considered to have an infinite life and is not depreciated.

2) Assets in the course of construction and residual interests in off-balance sheet (SoFP) PFI contract assets are not depreciated until the asset is brought into use or reverts to the Board, respectively.

3) Property, Plant and Equipment which has been reclassified as 'Held for Sale' ceases to be depreciated upon the reclassification.

4) Buildings, installations and fittings are depreciated on current value over the estimated remaining life of the asset, as advised by the appointed valuer. They are assessed in the context of the maximum useful lives for building elements.

5) Equipment is depreciated over the estimated life of the asset.

6) Property, plant and equipment held under finance leases are depreciated over the shorter of the lease term and the estimated useful life.

Depreciation is charged on a straight line basis.

The following asset lives have been used:

Asset Category/Component	Useful Life (years)
Structure (Shell)	25 - 100
Engineering	25–100
External Works	25 – 60
Medical Equipment	3 – 10
Other Non Clinical Equipment	3 – 10
Furniture	5 – 10
Vehicles	3 – 7
IT Mainframe Installations	3 – 7
IT Equipment	3 – 7
Intangible assets	3 – 7

8. Intangible Assets

8.1 Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Board's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Board and where the cost of the asset can be measured reliably.

Intangible assets that meet the recognition criteria are capitalised when they are capable of being used in a Board's activities for more than one year and they have a cost of at least £5,000.

The main classes of intangible assets recognised are:

Software:
Software which is integral to the operation of hardware e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware e.g. application software, is capitalised as an intangible asset.

Software licences:
Purchased computer software licences are capitalised as intangible assets where expenditure of at least £5,000 is incurred.

8.2 Measurement

Valuation:

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets that are not held for their service potential (i.e. assets held for sale), including operational assets which are surplus to requirements where there are no restrictions on disposal which would prevent access to the market, are measured at fair value. Where an active (homogeneous) market exists, intangible assets are carried at fair value. Where no active market exists, the intangible asset is revalued, using indices or some suitable model, to the lower of depreciated replacement cost and value in use where the asset is income generating. Where there is no value in use, the intangible asset is valued using depreciated replacement cost. These measures are a proxy for fair value.

Revaluation and impairment:

Increases in asset values arising from revaluations are recognised in the revaluation reserve except where, and to the extent that, they reverse an impairment previously recognised in the SoCCNE, in which case they are recognised in income.

Permanent decreases in asset values and impairments are charged gross to the SoCCNE. Any related balance on the revaluation reserve is transferred to the General Fund.

Temporary decreases in asset values or impairments are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned and thereafter are charged to the SoCCNE.

Intangible assets held for sale are reclassified to ‘non-current assets held for sale’ measured at the lower of their carrying amount or ‘fair value less costs to sell’.

Operational assets which are in use delivering front line services or back office functions, and surplus assets with restrictions on their disposal, are valued at current value in existing use. Assets have been assessed as surplus where there is no clear plan to bring the asset back into future use as an operational asset.

8.3 Amortisation

Intangible assets are amortised to their estimated residual value over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

Amortisation is charged to the SoCCNE on each main class of intangible asset as follows:

1) Software. Amortised over their expected useful life.

2) Software licences. Amortised over the shorter term of the licence and their useful economic lives.

Amortisation is charged on a straight line basis.

The following asset lives have been used:

Asset Category/Component	Useful Life (years)
Software	3 - 7
Software Licences	3 - 7

9. Donated Assets

Non-current assets that are donated or purchased using donated funds are included in the SoFP initially at the current full replacement cost of the asset. The accounting treatment, including the method of valuation, follows the rules in the NHS Capital Accounting Manual.

10. Sale of Property, plant and equipment, intangible assets and non-current assets held for sale

Disposal of non-current assets is accounted for as a reduction to the value of assets equal to the net book value of the assets disposed. When set against any sales proceeds, the resulting gain or loss on disposal will be recorded in the SoCCNE. Non-current assets held for sale will include assets transferred from other categories and will reflect any resultant changes in valuation.

11. Leasing

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the Board, the asset is recorded as Property, Plant and Equipment and a corresponding liability is recorded. Assets held under finance leases are valued at their fair value and are depreciated over the remaining period of the lease in accordance with IFRS.

The asset and liability are recognised at the inception of the lease and are de-recognised when the liability is discharged, cancelled or expires. The minimum lease payments (annual rental less operating costs e.g. maintenance and contingent rental) are apportioned between the repayment of the outstanding liability and a finance charge. The annual finance charged is allocated to each period during the lease so as to produce a constant periodic rate of interest on the remaining balance of the liability using either the implicit interest rate or another relevant basis of estimation such as the sum of the digits method. Finance charges are recorded as interest payable in the SoCCNE. Contingent rental and operating costs are charged as expenses in the periods in which they are incurred.

Operating leases

Other leases are regarded as operating leases and the rentals are charged to expenditure on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to expenditure over the life of the lease.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately. Leased land is treated as an operating lease unless title to the land is expected to transfer.

12. Impairment of non-financial assets

Assets that are subject to depreciation and amortisation are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount may not be recoverable. An impairment loss is recognised for the amount by which the asset's carrying amount exceeds its recoverable amount. The recoverable amount is the higher of an asset's fair value less costs to sell and value in use. Where an asset is not held for the purpose of generating cash flows, value in use is assumed to equal the cost of replacing the service potential provided by the asset, unless there has been a reduction in service potential. For the purposes of assessing impairment, assets are grouped at the lowest levels for which there are separately identifiable cash flows (cash-generating units). Non-financial assets that suffer an impairment are reviewed for possible reversal of the impairment. Impairment losses charged to the SoCCNE are deducted

from future operating costs to the extent that they are identified as being reversed in subsequent revaluations.

13. General Fund Receivables and Payables

Where the Health Board has a positive net cash book balance at the year end, a corresponding creditor is created and the general fund debited with the same amount to indicate that this cash is repayable to the SGHSCD. Where the Health Board has a net overdrawn cash position at the year end, a corresponding debtor is created and the general fund credited with the same amount to indicate that additional cash is to be drawn down from the SGHSCD.

14. Inventories

Inventories are valued at the lower of cost and net realisable value. Taking into account the high turnover of NHS inventories, the use of average purchase price is deemed to represent current cost.

15. Losses and Special Payments

Operating expenditure includes certain losses which would have been made good through insurance cover had the NHS not been bearing its own risks. Had the NHS provided insurance cover, the insurance premiums would have been included as normal revenue expenditure.

16. Employee Benefits

Short-term Employee Benefits

Salaries, wages and employment-related payments are recognised in the year in which the service is received from employees. The cost of annual leave and flexible working time entitlement earned but not taken by employees at the end of the year is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following year.

Pension Costs

The Board participates in the NHS Superannuation Scheme (Scotland). This scheme is an unfunded statutory pension scheme with benefits underwritten by the UK Government. The scheme is financed by payments from employers and those current employees who are members of the scheme and paying contributions at progressively higher marginal rates based on pensionable pay as specified in the regulations. The Board is unable to identify its share of the underlying notional assets and liabilities of the scheme on a consistent and reasonable basis and therefore accounts for the scheme as if it were defined contribution scheme, as required by IAS 19 'Employee Benefits'. As a result, the amount charged to the SoCCNE represents the Board's employer contributions payable to the scheme in respect of the year. The contributions deducted from employees are reflected in the gross salaries charged and are similarly remitted to the Exchequer. The pension cost is assessed every four years by the Government Actuary and this valuation determines the rate of contributions required. The most recent actuarial valuation is published by the Scottish Public Pensions Agency and is available on their website.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the SoCCNE at the time the Board commits itself to the retirement, regardless of the method of payment.

Pension costs for staff transferred from The Highland Council (THC)

As part of the terms and conditions of employment for the staff transferred from THC, the Board participates in the Local Government Pension Scheme administered by THC. This is a funded scheme, meaning that the authority and employees pay contributions into a fund, calculated at a level intended to balance the pension liabilities with investment assets. The Board recognises

the cost of these retirement benefits in the SoCCNE when they are earned by these employees, rather than when the benefits are eventually paid as pensions. Highland Council recognises the liability at 01/04/2012 attributable to these NHS Highland staff in the THC accounts. Any gain or shortfall in the value of the fund attributable to NHS Highland staff in year is charged to the SoCCNE.

17. Clinical and Medical Negligence Costs

Employing health bodies in Scotland are responsible for meeting medical negligence costs up to a threshold per claim. Costs above this threshold are reimbursed to Boards from a central fund held as part of the Clinical Negligence and Other Risks Indemnity Scheme (CNORIS) by the Scottish Government.

NHS Highland provide for all claims notified to the NHS Central Legal Office according to the value of the claim and the probability of settlement. Claims assessed as 'Category 3' are deemed most likely and provided for in full, those in 'Category 2' as 50% of the claim and those in 'category 1' as nil. The balance of the value of claims not provided for is disclosed as a contingent liability. This procedure is intended to estimate the amount considered to be the liability in respect of any claims outstanding and which will be recoverable from CNORIS in the event of payment by an individual health body. The corresponding recovery in respect of amounts provided for is recorded as a debtor and that in respect of amounts disclosed as contingent liabilities are disclosed as contingent assets.

NHS Highland also provides for its liability from participating in the scheme. The Participation in CNORIS provision recognises the Board's respective share of the total liability of NHS Scotland as advised by the Scottish Government and based on information prepared by NHS Boards and the Central Legal Office. The movement in the provisions between financial years is matched by a corresponding adjustment in AME provision and is classed as non-core expenditure.

18. Related Party Transactions

Material related party transactions are disclosed in the note 24 in line with the requirements of IAS 24. Transactions with other NHS bodies for the commissioning of health care are summarised in Note 3.

19. Value Added Tax

Most of the activities of the Board are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of non current assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

20. PFI/HUB/NPD Schemes

Transactions financed as revenue transactions the Private Finance Initiative or alternative initiatives such as HUB or the Non-Profit Distribution Model (NPD) are accounted for in accordance with the HM Treasury application of IFRIC 12, Service Concession Arrangements outlined in the FReM.

Schemes which do not fall within the application of IFRIC 12 are deemed to be off-balance sheet. Where the Board has contributed assets, a prepayment for their fair value is recognised and amortised over the life of the PFI contract by charge to the SoCCNE. Where, at the end of the PFI contract, a property reverts to the Board, the difference between the expected fair value of the residual on reversion and any agreed payment on reversion is built up on the SoFP over the life of the contract by capitalising part of the unitary charge each year.

Transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-balance sheet' (SoFP) by the Board. The underlying

assets are recognised as Property, Plant and Equipment and Intangible Assets at their fair value. An equivalent liability is recognised in accordance with IAS 17. Where it is not possible to separate the finance element from the service element of unitary payment streams, this has been estimated from information provided by the operator and the fair values of the underlying assets. Assets are subsequently revalued in accordance with the treatment specified for their applicable asset categories.

The annual contract payments are apportioned between the repayment of the liability, a finance cost and the charges for services. The finance cost is calculated using the implicit interest rate for the scheme.

The service charge and the finance cost interest element are charged in the SoCCNE.

21. Provisions

The Board provides for legal or constructive obligations that are of uncertain timing or amount at the SoFP date on the basis of the best estimate of the expenditure required to settle the obligation. Where the effect of the time value of money is significant, the estimated cash flows are discounted using the discount rate prescribed by HM Treasury.

22. Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the Board's control) are not recognised as assets, but are disclosed in note 14 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 14, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

a) possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or

b) present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

23. Corresponding Amounts

Corresponding amounts are shown for the primary statements and notes to the financial statements. Where the corresponding amounts are not directly comparable with the amount to be shown in respect of the current financial year, IAS 1 'Presentation of Financial Statements', requires that they should be adjusted and the basis for adjustment disclosed in a note to the financial statements.

24. Financial Instruments

Financial assets

Business model
The Board's business model refers to how it manages its financial assets in order to generate cash flows and is determined at a level which reflects how groups of financial assets are managed to achieve a business objective, rather than assessment of individual instruments.

Classification
When the Board first recognises a financial asset, it classifies it based on its business model for managing the asset and the asset's contractual flow characteristics. The Board classifies its financial assets in the following categories: at fair value through profit or loss

(a) Financial assets at fair value through profit or loss

This is the default basis for financial assets.

(b) Financial assets held at amortised cost

A financial asset may be held at amortised cost where both of the following conditions are met:

i. the financial asset is held within a business model where the objective is to collect contractual cash flows; and

ii. the contractual terms of the financial asset give rise to cash flows that are solely payments of principal and related interest.

(c) Financial assets at fair value through other comprehensive income

A financial asset may be held at fair value through other comprehensive income where both of the following conditions are met:

i. the financial asset is held within a business model where the objective is to collect contractual cash flows *and* sell the asset; and

ii. the contractual terms of the financial asset give rise to cash flows that are solely payments of principal and related interest.

Impairment of financial assets
Provisions for impairment of financial assets are made on the basis of expected credit losses. The Board recognises a loss allowance for expected credit losses on financial assets and this is recognised in other comprehensive income, rather than reducing the carrying amount of the asset in the SoFP.

Lifetime expected credit losses are recognised and applied to financial assets by the Board where there has been a significant increase in credit risk since the asset's initial recognition. Where the Board does not hold reasonable and supportable information to measure lifetime expected credit losses on an individual instrument basis, the losses are recognised on a collective basis which considers comprehensive credit risk information.

Recognition and measurement
Financial assets are recognised when the Board becomes party to the contractual provisions of the financial instrument.

Financial assets are derecognised when the rights to receive cash flows from the asset have expired or have been transferred and the Board has transferred substantially all risks and rewards of ownership.

(a) Financial assets at fair value through profit or loss

Financial assets carried at fair value through profit or loss are initially recognised at fair value, and transaction costs are expensed in the Statement of Comprehensive Net Expenditure.

Financial assets carried at fair value through profit or loss are subsequently measured at fair value. Gains or losses arising from changes in the fair value are presented in the Statement of Comprehensive Net Expenditure.

(b) Financial assets held at amortised cost

Loans and receivables are recognised initially at fair value and subsequently measured at amortised cost using the effective interest method. This is calculated by applying the effective interest rate to the gross carrying amount of the asset.

(c) Financial assets held at fair value through other comprehensive

Financial Liabilities

Classification
The Board classifies its financial liabilities in the following categories: at fair value through profit or loss, and amortised cost. The Board classifies all financial liabilities as measured at amortised cost, unless:

i. these are measured at fair value on a portfolio basis in accordance with a documented risk management or investment strategy;
ii. they contain embedded derivatives; and/or
iii. it eliminates or reduces 'accounting mismatch' that would otherwise arise from measurement or recognition on an amortised costs basis.

a) Financial liabilities at fair value through profit or loss

Financial liabilities at fair value through profit or loss comprise derivatives. Liabilities in this category are classified as current liabilities. The Board does not trade in derivatives and does not apply hedge accounting.

(b) Financial liabilities held at amortised cost

Financial liabilities held at amortised cost are disclosed in current liabilities, except for maturities greater than 12 months after the SoFP date. These are classified as non-current liabilities. The Board's financial liabilities held at amortised cost comprise trade and other payables in the SoFP.

Recognition and measurement
Financial liabilities are recognised when the Board becomes party to the contractual provisions of the financial instrument.

A financial liability is removed from the SoFP when it is extinguished, that is when the obligation is discharged, cancelled or expired.

(a) Financial liabilities at fair value through profit or loss

Financial liabilities carried at fair value through profit or loss are initially recognised at fair value, and transaction costs are expensed in the income statement.

Financial liabilities carried at fair value through profit or loss are subsequently measured at fair value. Gains or losses arising from changes in the fair value are presented in the SoCCNE.

Amortised costs

Financial liabilities held at amortised cost are recognised initially at fair value and subsequently measured at amortised cost using the effective interest method.

25. Segmental reporting

Operating segments are reported in a manner consistent with the internal reporting provided to the chief operating decision-maker, who is responsible for allocating resources and assessing performance of the operating segments. This has been identified as the senior management of the Board.

Operating segments are unlikely to directly relate to the analysis of expenditure shown in note 3.

26. Cash and cash equivalents

Cash and cash equivalents includes cash in hand, deposits held at call with banks, cash balances held with the Government Banking Service, balances held in commercial banks and other short-term highly liquid investments with original maturities of three months or less, and bank overdrafts. Bank overdrafts are shown within borrowings in current liabilities on the SOFP. Where the Government Banking Service is using the National Westminster Bank to provide the banking services, funds held in these accounts should not be classed as commercial bank balances.

27. Foreign exchange

The functional and presentational currencies of the Board are sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the Board has assets or liabilities denominated in a foreign currency at the SoFP date:

- monetary items (other than financial instruments measured at 'fair value through income and expenditure') are translated at the spot exchange rate on 31 March;
- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction; and
- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the SoFP date) are recognised in income or expenditure in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

28. Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Board has no beneficial interest in them. However, they are disclosed in note 24 to the accounts in accordance with the requirements of HM Treasury's Financial Reporting Manual.

29. Key sources of judgement and estimation uncertainty

Estimates and judgements are continually evaluated and are based on historical experience and other factors, including expectations of future events that are believed to be reasonable under the circumstances.

The Board makes estimates and assumptions concerning the future. The resulting accounting estimates will, by definition, seldom equal the related actual results. The Board makes judgements in applying accounting policies. The estimates, assumptions and judgements that

have a significant risk of causing material adjustment to the carrying amounts of assets and liabilities within the financial statements within the next financial year are addressed below.

Judgements

Assessment of Leases

Leases are assessed under IFRS as being operating or finance leases, which determine their accounting treatment. The criteria for assessment are, to a certain extent subjective, but a consistent approach has been taken through the use of a standard template which sets out the relevant criteria. See Note 17 for summary of these leases.

Pension Liability for The Highland Council Pension Fund used by Social Care staff transferred to NHS Highland

In accordance with SGHSCD guidance, obligations under the defined benefit pension scheme are fully funded via Scottish Government funding in advance and therefore as a departure from IAS 19: Employee Benefits, the defined benefit obligations are not recognised as a long term liability and instead recognised through other reserves as SGHSCD funding received in advance. For further information see note 19.

Estimation of the liability to pay pensions for these staff depends on a number of complex judgements relating to the discount rates used, the rate at which salaries are projected to increase, changes in retirement ages, mortality rates and expected returns on pension fund assets.

The effects on the net pensions liability of changes in individual assumptions can be measured. For example, a 0.1% increase in the discount rate assumption would result in a decrease of approximately £183,000 in the pension liability.

Reliance is placed on significant details provided by the actuary of the Pension Fund to establish the value of this liability.

See Note 19 for detailed information on this liability.

Estimates

Property Plant and Equipment

The Board commissioned a valuation for 31 March 2022.

The valuation report has been used to inform the measurement of assets in these financial statements. The valuer has exercised professional judgement in preparing the valuation and, therefore, this is the best information available to NHS Highland as at 31 March 2022. See Note 7 for analysis.

Highland Health Board

NOTES TO THE ACCOUNTS for the Year Ended 31 March 2022

2a SUMMARY OF CORE RESOURCE OUTTURN for the year ended 31 March 2022

	Note	2022 £000
Net Expenditure	SoCNE	**968,276**
Total Non Core Expenditure (see below)		(32,815)
Family Health Services Non-Discretionary Allocation		(38,560)
Endowment Net Expenditure		(35)
Associates and joint ventures accounted for on an equity basis		7,332
Total Core Expenditure		**904,198**
Core Revenue Resource Limit		904,653
Saving/(excess) against Core Revenue Resource Limit		**455**
SUMMARY OF NON CORE REVENUE RESOURCE OUTTURN		
Capital Grants to Other Bodies		462
Depreciation/Amortisation		15,897
Annually Managed Expenditure - Impairments		6,523
Annually Managed Expenditure – Creation of Provisions		1,364
Annually Managed Expenditure – Depreciation of Donated Assets	7a	147
Annually Managed Expenditure – Pension Valuation		5,707
Additional Scottish Government non-core funding		1,984
Donated asset income		(16)
IFRS PFI Expenditure		747
Total Non Core Expenditure		**32,815**
Non Core Revenue Resource Limit		32,815
Saving/(against) Non Core Revenue Resource Limit		**0**

SUMMARY RESOURCE OUTTURN	**Resource**	**Expenditure**	**Saving**
	£000	**£000**	**£000**
Core	904,653	904,198	455
Non Core	32,815	32,815	0
Total	**937,468**	**937,013**	**455**

Highland Health Board

NOTES TO THE ACCOUNTS for the Year Ended 31 March 2022

STATEMENT OF CONSOLIDATED CASH FLOWS for the year ended 31 March 2022

2b NOTES TO THE CASH FLOW STATEMENT

2b Consolidated adjustments for non-cash transactions

2021 £000		Note	2022 £000
	Expenditure not paid in cash		
14,750	Depreciation	7a	15,965
796	Amortisation	6	679
159	Depreciation of donated assets	7a	147
12	Impairments on PPE charged to SoCCNE		6,523
0	Net revaluation on PPE charged to SoCCNE		0
(10)	Funding of donated assets	7a	(16)
(69)	Loss/(profit) on disposal of property, plant and equipment		(17)
(3,293)	Associates and joint ventures accounted for on an equity basis	SoCNE	(7,332)
(9,335)	THC ASC Pension movements		16,281
8,531	D Of H equip & Covid pass through £500 payments		(2,007)
11,541	**Total expenditure not paid in cash**	CFS	30,223

2021 £000			2022 £000
	Interest Payable		
	Bank and other interest payable		
1,819	PFI Finance lease charges allocated in the year	18	1,981
514	Other Finance lease charges allocated in the year		151
454	Provisions – Unwinding of discount		333
2,787	**Net interest payable**	CFS	**2,465**

Highland Health Board

NOTES TO THE ACCOUNTS for the Year Ended 31 March 2022

2 NOTES TO THE CASH FLOW STATEMENT, Contd

2b Consolidated Movements in Working Capital

2021 Net Movement £000		Note	Opening Balances £000	Closing Balances £000	2022 Net Movement £000
	INVENTORIES				
	SoFP	8	6,406	7,236	
922	**Net decrease (increase)**				**(830)**
	TRADE AND OTHER RECEIVABLES				
	Due within one year	9	52,628	45,377	
	Due after more than one year	9	11,300	26,978	
			63,928	72,355	
5,389	**Net decrease/(increase)**				(8,427)
	TRADE AND OTHER PAYABLES				
	Due within one year	12	136,430	149,214	
	Due after more than one year	12	32,484	27,731	
	Less: property, plant & equipment (capital) included in above		(2,063)	(11,459)	
	Less: General Fund creditor included in above	12	(88)	0	
	Less: lease and PFT creditors included in above	12	(28,997)	(26,572)	
			137,766	138,915	
43,514	**Net Increase/(decrease)**				**1,149**
	PROVISIONS				
	Statement of Financial Position	13a	60,847	60,023	
			60,847	60,023	
4,332	**Net Increase/(decrease)**				**(824)**
54,157	**Net movement increase/(decrease)**	CFS			**(8,932)**

Highland Health Board

NOTES TO THE ACCOUNTS for the Year Ended 31 March 2022

3 OPERATING EXPENSES

3a Staff Costs

2021 Consolidated £000			2022 Board £000	2022 Consolidated £000
94,884	Medical and Dental		101,596	101,596
171,498	Nursing		172,550	172,550
202,128	Other Staff		218,438	218,438
468,510	**Total**	SoCNE	**492,584**	**492,584**

Further detail and analysis of employee costs can be found in the Remuneration and Staff Report, forming part of the Accountability Report.

3b Other Operating Expenditure

2021 Consolidated £000		2022 Board £000	2022 Consolidated £000
	Independent Primary Care Services:		
65,563	General Medical Services	70,185	70,185
17,387	Pharmaceutical Services	16,807	16,807
17,324	General Dental Services	18,370	18,370
6,069	General Ophthalmic Services	5,959	5,959
106,343	**Total**	**111,321**	**111,321**
	Drugs and Medical Supplies:		
64,136	Prescribed drugs Primary Care	67,037	67,037
38,217	Prescribed drugs Secondary Care	42,189	42,189
12,632	PPE and Testing Kits	15,367	15,367
23,905	Medical Supplies	29,459	29,459
138,890	**Total**	**154,052**	**154,052**
	Other Health Care Expenditure:		
254,245	Contribution to Integration Joint Boards	269,993	269,993
98,702	Goods & services from other NHS Scotland bodies	105,412	105,412
614	Goods & services from other UK NHS bodies	549	549
8,590	Goods & services from private providers	12,064	12,064
5,975	Goods & services from voluntary organisations	5,579	5,579
	Resource Transfer	0	0
1	Loss on disposal of assets	90	90
242,172	Other operating expenses	251,399	251,399
188	External Auditor's Statutory Audit Fee	190	190
	Endowment Fund expenditure		680
662			
611,145	**Total**	**645,276**	**645,956**
856,378	**Total Other Operating Expenditure**	**910,649**	**911,329**

Highland Health Board

NOTES TO THE ACCOUNTS for the Year Ended 31 March 2022

4 OPERATING INCOME

2021 Consolidated £000		Note	2022 Board £000	2022 Consolidated £000
0	Income from Scottish Government		42	42
32,649	Income from other NHS Scotland bodies		36,476	36,476
1,218	Income from NHS non-Scottish bodies		2,423	2,423
22	Income from private patients		8	8
230,529	Income for services commissioned by Integration Joint Board		239,365	239,365
888	Patient charges for primary care		2,281	2,281
3,705	Donated income and asset additions		10,480	10,480
69	Profit on disposal of assets		17	17
1,445	Contributions in respect of clinical and medical negligence claims		1,708	1,708
30	Interest received	CFS	11	11
	Non NHS:			
54	Overseas patients (non-reciprocal)		139	139
911	Endowment Fund Income			645
129,191	Other		134,710	134,710
400,711	**Total Income**	SoCNE	**427,660**	**428,305**

NOTES TO THE ACCOUNTS for the Year Ended 31 March 2022

5 SEGMENTAL INFORMATION

Segmental information as required under IFRS has been reported for each strategic objective

	Acute	North Highland Communities inc ASC	ASC Funding	Mental Health	Primary Care	Childrens Services	Corporate eHealth & Tertiary	Central	Facilities	A & B	2022
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net Operating Costs	254,491	223,995	(105,328)	41,616	139,714	11,652	84,214	50,686	42,958	231,575	975,573

PRIOR YEAR

Segmental information as required under IFRS has been reported for each strategic objective

	Acute	North Highland Communities inc ASC	ASC Funding	Mental Health	Primary Care	Childrens Services	Corporate eHealth & Tertiary	Central	Facilities	A & B	2021
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net Operating Costs	221,682	194,859	(100,901)	39,869	137,013	11,500	63,059	95,164	39,255	222,926	924,426

Highland Health Board

NOTES TO THE ACCOUNTS for the Year Ended 31 March 2022

6a Intangible Assets (Non-Current) – Board and Consolidated

	Note	Software Licences £000	IT – Software £000	Total £000
Cost or Valuation:				
At 1 April 2021		2,227	5,566	7,793
Additions		515	157	672
Disposals				
At 31 March 2022		**2,742**	**5,723**	**8,465**
Amortisation				
At 1 April 2021		1,612	4,438	6,050
Provided during the year		290	389	679
Disposals				
At 31 March 2022		**1,902**	**4,827**	**6,729**
Net book value at 1 April 2021		**615**	**1,128**	**1,743**
Net book value at 31 March 2022	SoFP	**840**	**896**	**1,736**

6a Intangible Assets (Non-Current) – Board and Consolidated Prior Year

	Note	Software Licences £000	IT – Software £000	Total £000
Cost or Valuation:				
At 1 April 2020		2,170	5,227	7,397
Additions		57	339	396
Disposals		0	0	0
At 31 March 2021		**2,227**	**5,566**	**7,793**
Amortisation				
At 1 April 2020		1,303	3,951	5,254
Provided during the year		309	487	796
Disposals		0	0	0
At 31 March 2021		**1,612**	**4,438**	**6,050**
Net book value at 1 April 2020		**867**	**1,276**	**2,143**
Net book value at 31 March 2021	SoFP	**615**	**1,128**	**1,743**

Highland Health Board

NOTES TO THE ACCOUNTS for the Year Ended 31 March 2022

7a PROPERTY, PLANT AND EQUIPMENT – CONSOLIDATED AND BOARD

	Note	Land (including under buildings)	Buildings (excluding dwellings)	Dwellings	Transport Equipment	Plant & Machinery	Information Technology	Furniture & Fittings	Assets Under Construction	Total
		£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or Valuation										
At 1 April 2021		**21,171**	**308,920**	**5,762**	**259**	**73,838**	**9,633**	**1,785**	**55,596**	**476,964**
Additions - purchased									64,275	64,275
Additions - donated		0	0	0	0	16	0	0	0	16
Completions		0	63,522	1,309	42	13,564	468	0	(78,905)	0
Revaluations		0	22,486	497	0	0	0	0	0	22,983
Impairment charges		(56)	(6,492)	0	0	0	0	0	0	(6,548)
Disposals - purchased		(20)	(116)	0	(149)	(2,094)	(12)	(16)	0	(2,407)
Disposals - donated		0	0	0	0	(15)	0	0	0	(15)
As 31 March 2022		**21,095**	**388,320**	**7,568**	**152**	**85,309**	**10,089**	**1,769**	**40,966**	**555,268**
Depreciation										
At 1 April 2021		**0**	**24,143**	**436**	**247**	**46,876**	**6,758**	**1,753**	**0**	**80,213**
Provided during the year - purchased		0	8,977	338	1	5,700	940	9	0	15,965
Provided during the year - donated		0	94	6	1	44	2	0	0	147
Revaluations		0	(429)	(18)	0	0	0	0	0	(447)
Impairment charges		0	(25)	0	0	0	0	0	0	(25)
Disposals - purchased		0	(33)	0	(149)	(2,078)	(12)	(16)	0	(2,288)
Disposals - donated		0	0	0	0	(15)	0	0	0	(15)
At 31 March 2022		**0**	**32,727**	**762**	**100**	**50,527**	**7,688**	**1,746**	**0**	**93,550**
Net book value at 1 April 2021		**21,171**	**284,777**	**5,326**	**12**	**26,962**	**2,875**	**32**	**55,596**	**396,751**
Net book value at 31 March 2022	SoFP	**21,095**	**355,593**	**6,806**	**52**	**34,782**	**2,401**	**23**	**40,966**	**461,718**

NOTES TO THE ACCOUNTS for the Year Ended 31 March 2022

7a PROPERTY, PLANT AND EQUIPMENT – CONSOLIDATED, Contd

	Note	Land (including under buildings)	Buildings (excluding dwellings)	Dwellings	Transport Equipment	Plant & Machinery	Information Technology	Furniture & Fittings	Assets Under Construction	Total
		£000	£000	£000	£000	£000	£000	£000	£000	£000
Open Market Value of Land in Land & Dwellings included above		272		216						
Asset financing:										
Owned - Purchased		21,050	309,616	6,570	43	34,706	2,396	23	40,965	415,369
Owned - Donated		45	3,927	236	9	76	5	0	0	4,298
Held on finance lease		0	604	0	0	0	0	0	0	604
On-balance sheet PFI contracts		0	41,446	0	0	0	0	0	1	41,447
Net book value at 31 March 2022	SoFP	**21,095**	**355,593**	**6,806**	**52**	**34,782**	**2,401**	**23**	**40,966**	**461,718**

NOTES TO THE ACCOUNTS for the Year Ended 31 March 2022

7a PROPERTY, PLANT AND EQUIPMENT – CONSOLIDATED AND BOARD PRIOR YEAR

	Note	Land (including under buildings)	Buildings (excluding dwellings)	Dwellings	Transport Equipment	Plant & Machinery	Information Technology	Furniture & Fittings	Assets Under Construction	Total
		£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or Valuation										
At 1 April 2020		**19,878**	**313,306**	**5,880**	**279**	**63,671**	**8,602**	**1,785**	**20,617**	**434,018**
Additions - purchased		0	0	0	0	0	0	0	54,260	54,260
Additions - donated		0	0	0	0	10	0	0	0	10
Completions		1,306	4,440	(4)	0	12,508	1,031	0	(19,281)	0
Revaluations		0	(8,777)	(114)	0		0	0	0	(8,891)
Impairment charges		0	(22)	0	0		0	0	0	(22)
Disposals - purchased		(13)	(27)	0	(20)	(2299)	0	0	0	(2,359)
Disposals - donated		0	0	0	0	(52)	0	0	0	(52)
As 31 March 2021		**21,171**	**308,920**	**5,762**	**259**	**73,838**	**9,633**	**1,785**	**55,596**	**476,964**
Depreciation										
At 1 April 2020		**0**	**21,443**	**237**	**266**	**44,656**	**5,903**	**1,699**	**0**	**74,204**
Provided during the year - purchased		0	8,991	339	0	4,514	852	54	0	14,750
Provided during the year - donated		0	94	6	1	55	0	0	0	159
Revaluations		0	(6365)	(146)	0	0	0	0	0	(6,511)
Impairment charges		0	(10)	0	0	0	0	0	0	(10)
Disposals - purchased		0	(10)	0	(20)	(2,299)	0	0	0	(2,329)
Disposals - donated		0	0	0	0	(50)	0	0	0	(50)
At 31 March 2021		**0**	**24,143**	**436**	**247**	**46,876**	**6,758**	**1,753**	**0**	**80,213**
Net book value at 1 April 2020		**19,878**	**291,863**	**5,643**	**13**	**19,015**	**2,699**	**86**	**20,617**	**359,814**
Net book value at 31 March 2021		**21,171**	**284,777**	**5,326**	**12**	**26,962**	**2,875**	**32**	**55,596**	**396,751**

NOTES TO THE ACCOUNTS for the Year Ended 31 March 2022

7a PROPERTY, PLANT AND EQUIPMENT – CONSOLIDATED PRIOR YEAR, Contd

	Note	Land (including under buildings)	Buildings (excluding dwellings)	Dwellings	Transport Equipment	Plant & Machinery	Information Technology	Furniture & Fittings	Assets Under Construction	Total
		£000	£000	£000	£000	£000	£000	£000	£000	£000
Open Market Value of Land in Land and Dwellings Included Above		272		230						
Asset financing:										
Owned - purchased		21,126	241,494	5,101	2	26,858	2,868	32	55,596	353,077
Owned - donated		45	3,771	225	10	104	7	0	0	4,162
Held on finance lease		0	727	0	0	0	0	0	0	727
On-balance sheet PFI contracts		0	38,78	0	0	0	0	0	0	38,785
Net book value at 31 March 2021	SoFP	**21,171**	**284,777**	**5,326**	**12**	**26,962**	**2,875**	**32**	**55,596**	**396,751**

.

NOTES TO THE ACCOUNTS for the Year Ended 31 March 2022

7c PROPERTY, PLANT AND EQUIPMENT DISCLOSURES

Consolidated 2021 £000	Board 2021 £000		Note	Consolidated 2022 £000	Board 2022 £000
		Net book value of property, plant and equipment at 31 March			
392,589	392,589	Purchased		457,420	457,420
4,162	4,162	Donated		4,298	4,298
396,751	**396,751**	**Total**	SoFP	**461,718**	**461,718**
272	272	Net book value related to land valued at open market value at 31 March		272	272
230	230	Net book value related to buildings valued at open market value at 31 March		216	216
		Total value of assets held under:			
727	727	Finance Leases		604	604
0	0	Hire Purchase Contracts		0	0
38,785	38,785	PFI and PPP Contracts		41,447	41,447
39,512	**39,512**			**42,051**	**42,051**
		Total depreciation charged in respect of assets held under:			
122	122	Finance Leases		122	122
0	0	Hire Purchase Contracts		0	0
1,236	1,236	PFI and PPP Contracts		1252	1252
1,358	**1,358**			**1,374**	**1,374**

An annual valuation of 20% of all NHS Highland properties was carried by an independent valuer, Gerald Eve (Argyll & Bute) & FG Burnett (North Highland) in March 2022 on the basis of fair value (market value or depreciated replacement cost where appropriate). The values were computed in accordance with the Royal Institute of Chartered Surveyors Statement of Asset Valuation Practice and Guidance notes, subject to the special accounting practices of the NHS. Indexation is applied to those assets not subject to valuation.

The net impact was an increase of £16.907m (2020-21: a decrease of £2.392m) which was credited to the revaluation reserve. Impairment of £6.523m (2020-21 £0.012m) was charged to the Statement of Comprehensive Net Expenditure and Summary of Resource Outturn.

NOTES TO THE ACCOUNTS for the Year Ended 31 March 2022

7d. ANALYSIS OF CAPITAL EXPENDITURE

Consolidated 2021 £000	Board 2021 £000		Note	Consolidated 2022 £000	Board 2022 £000
		EXPENDITURE			
396	396	Acquisition of Intangible Assets	6	672	672
54,260	54,260	Acquisition of Property, Plant and Equipment	7a	64,275	64,275
10	10	Donated Asset Additions	7a	16	16
54,666	**54,666**	**Gross Capital Expenditure**		**64,963**	**64,963**
		INCOME			
30	30	Net book value of disposal of Property, Plant and Equipment	7a	119	119
2	2	Net book value of disposal of Donated Assets	7a	0	0
7	7	HUB – Repayment of investment		3	3
10	10	Donated Asset Income		0	0
49	**49**	**Capital Income**		**122**	**122**
54,617	**54,617**	**Net Capital Expenditure**		**64,841**	**64,841**
		SUMMARY OF CAPITAL RESOURCE OUTTURN			
54,617	54,617	Core Capital Expenditure included above		64,825	64,825
54,617	54,617	Core Capital Resource Limit		64,825	64,825
0	0	**Saving/(excess) against Core Capital Resource Limit**		0	0
		Non-Core Capital Expenditure included above		16	16
		Non-Core Capital Resource Limit		16	16
0	**0**	**Saving/(excess) against Non-Core Capital Resource Limit**		**0**	**0**
54,617	54,617	Total Capital Expenditure		64,841	64,841
54,617	54,617	Total Capital Resource Limit		64,841	64,841
0	**0**	**Saving/(excess) against Capital Resource Limit**		**0**	**0**

The discrepancy between 2020-21 net capital expenditure and Total Capital Resource Limit is due to the reclassification of accounting treatment of donated assets income received in that year. There is no impact on NHS Highland's performance in that year against the capital budget provided

8 INVENTORIES

Consolidated 2021 £000	Board 2021 £000		Note	Consolidated 2022 £000	Board 2022 £000
6,406	6,406	Raw Materials and Consumables		7,236	7,236
6,406	**6,406**	**Total Inventories**	SoFP	**7,236**	**7,236**

Highland Health Board

NOTES TO THE ACCOUNTS for the Year Ended 31 March 2022

9 TRADE AND OTHER RECEIVABLES

Consolidated 2021 £000	Board 2021 £000		Note	Consolidated 2022 £000	Board 2022 £000
		Receivables due within one year – NHS Scotland			
208	208	Scottish Government Health & Social Care Directorate		135	135
4,016	4016	Boards		4,207	4,207
4,224	**4,224**	**Total NHSScotland Receivables**		**4,342**	**4,342**
281	281	NHS Non-Scottish Bodies		529	529
1,328	1,328	VAT recoverable		1,229	1,229
5,925	5,925	Prepayments		8,303	8,303
4,175	4,175	Accrued income		5,073	5,073
629	725	Other Receivables		1,650	1,761
13,164	13,164	Reimbursement of provisions		7,100	7,100
22,902	22,902	Other Public Sector Bodies		17,151	17,151
52,628	**52,724**	**Total Receivables due within one year**	SoFP	**45,377**	**45,488**
0	0	Other Public Sector Bodies		4,756	4,756
1,338	1,338	Prepayments		1,272	1,272
5,461	5,461	Accrued income		4,652	4,652
17	17	Other Receivables		3,849	3,849
4,484	4,484	Reimbursement of Provisions		12,449	12,449
11,300	**11,300**	**Total Receivables due after more than one year**	SoFP	26,978	26,978
63,928	**64,024**	**TOTAL RECEIVABLES**		**72,355**	**72,466**

NOTES TO THE ACCOUNTS for the Year Ended 31 March 2022

9 TRADE AND OTHER RECEIVABLES, Contd

Consolidated 2021 £000	Board 2021 £000		Note	Consolidated 2022 £000	Board 2022 £000
1,896	1,896	The total receivables figure above includes a provision for impairments of:		1,672	1,672
		WGA Classification			
4,016	4,016	NHS Scotland		4,207	4,207
1,356	1,356	Central Government bodies		1,339	1,339
25,851	25,851	Whole of Government bodies		17,151	17,151
281	281	Balances with NHS Bodies in England & Wales		529	529
32,424	32,520	Balances with bodies external to Government		49,129	49,240
63,928	**64,024**	**Total**		**72,355**	**72,466**
		Movements on the provision for impairment of receivables are as follows:			
1,288	1,288	At 1 April		1,896	1,896
773	773	Provision for impairment		(139)	(139)
(247)	(247)	Receivables written off during the year as uncollectible		(85)	(85)
82	82	Unused amounts reversed		0	0
1,896	**1,896**	At 31 March		**1,672**	**1,672**

As of 31 March 2022, receivables with a carrying value of £1672m (2020-21: £1896m) were impaired and provided for. The ageing of these receivables is as follows:

2021 £000	2021 £000		2022 £000	2022 £000
		3 to 6 months past due		
1,896	1,896	Over 6 months past due	1,672	1,672
1,896	**1,896**		**1,672**	**1,672**

The receivables assessed as individually impaired were mainly (English, Welsh and Irish NHS Trusts/Health Authorities, other Health Bodies, overseas patients, research companies and private individuals) and it was assessed that not all of the receivable balance may be recovered.

Receivables that are less than three months past their due date are not considered impaired. As at 31 March 2022, receivables with a carrying value of £2.527 million (2020-21: £2.483 million) were past their due date but not impaired. The ageing of receivables which are past due but not impaired is as follows:

NOTES TO THE ACCOUNTS for the Year Ended 31 March 2022

9 TRADE AND OTHER RECEIVABLES, Cont

2021 £000	2021 £000		2022 £000	2022 £000
426	426	Up to 3 months past due	1,073	1,073
631	631	3 to 6 months past due	700	700
1,426	1,426	Over 6 months past due	754	754
2,483	**2,483**		**2,527**	**2,527**

The receivables assessed as past due but not impaired were mainly (NHS Scotland Health Boards, Local Authorities and Universities) and there is no history of default from these customers recently.

Concentration of credit risk is limited due to customer base being large and unrelated/government bodies. Due to this, management believe that there is no future credit risk provision required in excess of the normal provision for doubtful receivables.

The credit quality of receivables that are neither past due nor impaired is assessed by reference to external credit ratings where available. Where no external credit rating is available, historical information about counterparty default rates is used.

9 TRADE AND OTHER RECEIVABLES, Contd

2021 £000	2021 £000		2022 £000	2022 £000
		Currencies:		
63,928	64,024	Pounds	72,355	72,466
63,928	**64,024**		**72,355**	**72,466**

All non-current receivables are due within 13 years (2020-21 14 years) from the SoFP date.
The carrying amount of short term receivables that are financial instruments approximates their fair value.
The carrying value of long term other receivables is £26.978m (2020-21 £11.300m).
The effective interest rate on non-current other receivables is 0.0% (2020-21: 0.0%). Pension liabilities are discounted at -1.3% (2020-21: -0.95%).

Highland Health Board

NOTES TO THE ACCOUNTS for the Year Ended 31 March 2022

10 INVESTMENTS

Consolidated 2021 £000	Board 2021 £000		Note	Consolidated 2022 £000	Board 2022 £000
405		Government securities		396	
8,092	106	Other		8,300	102
8,497	**106**	**TOTAL**	SoFP	**8,696**	**102**
7,254	113	**At 1 April**		8,497	106
561		Additions	CFS	119	0
(409)	(7)	Disposals		(177)	(4)
1,091		Revaluation surplus / (deficit) transferred to equity	SoCTE	257	
8,497	**106**	**At 31 March**		**8,696**	**102**
8,497	106	Non-Current	SoFP	8,696	102
8,497	**106**	At 31 March		**8,696**	**102**

We have a small shareholding in HUB North of Scotland Ltd, an unlisted investment denominated in UK pounds; £102k in the form of non-equity long term loans repayable in full with interest over 25 years to HUB North of Scotland Ltd as part of the financing arrangements for the Forres, Woodside and Tain Health Centre Project. The carrying value of £102k of these investments is cost less impairment as there is no active market. Stocks and Bonds relate to the Highland Health Board Charitable Endowment Funds which are invested in a portfolio of bonds and equity investments, managed by the Funds appointed Investment Managers Adam & Company Investment Management Limited., in line with a medium risk strategy to deliver a balance between income and capital growth. The carrying value of Stocks and Bonds is market value.

11 CASH AND CASH EQUIVALENTS (Consolidated)

	Note	2022 £000	2021 £000
Balance at 1 April		971	2,010
Net change in cash and cash equivalent balances	CFS	(36)	(1,039)
Balance at 31 March	SoFP	**935**	**971**
Total Cash – Cash Flow Statement		935	971

The following balances at 31 March were held at:

Government Banking Services	31	4
Commercial banks and cash in hand	(16)	84
Endowment cash	920	883
Balance at 31 March	**935**	**971**

NOTES TO THE ACCOUNTS for the Year Ended 31 March 2022

12 TRADE AND OTHER PAYABLES

Consolidated 2021 £000	Board 2021 £000		Note	Consolidated 2022 £000	Board 2022 £000
		Payables due within one year NHS Scotland			
33,057	33,057	Boards		13,208	13,208
33,057	**33,057**	**Total NHSScotland Payables**		**13,208**	**13,208**
576	576	NHS Non-Scottish Bodies		1,039	1,039
88	88	Amounts payable to General Fund		0	0
10,740	10,740	FHS Practitioners		13,169	13,169
4,697	4,697	Trade Payables		6,883	6,883
47,526	47,510	Accruals		39,979	39,960
1,650	1,650	Deferred income		1,638	1,638
85	85	Payments received on account		247	247
236	236	Net obligations under Finance Leases	17	256	256
2,195	2,195	Net obligations under PPP/PFI Contracts	18	2,415	2,415
8,818	8,818	Income tax and social security		9,480	9,480
7,107	7,107	Superannuation		7,587	7,587
5,513	5,513	Holiday Pay Accrual		7,545	7,545
6,509	6,509	Other Public Sector Bodies		34,640	34,640
7,304	7,304	Other payables		10,816	10,816
329	329	Other significant Payable - Pension contribution to Local Gvt Pension Scheme		312	312
136,430	**136,414**	**Total Payables due within one year**	SoFP	**149,214**	**149,195**

NOTES TO THE ACCOUNTS for the Year Ended 31 March 2022

12 TRADE AND OTHER PAYABLES, Contd

Consolidated 2021 £000	Board 2021 £000		Note	Consolidated 2022 £000	Board 2022 £000
		Payables due after more than one year			
		Other public sector bodies			
259	259	Net obligations under Finance Leases due within 2 years		283	283
823	823	Net obligations under Finance Leases due after 2 years but within 5 years		591	591
228	228	Net obligations under Finance Leases due after 5 years		187	187
2,415	2,415	Net obligations under PPP/PFI Contracts due within 2 years	18	2,661	2,661
7,657	7,657	Net obligations under PPP/PFI Contracts after 2 years but within 5 years	18	6,401	6,401
15,184	15,184	Net obligations under PPP/PFI Contracts due after 5 years	18	13,777	13,777
5,918	5,918	Other payables		3,831	3,831
32,484	**32,484**	**Total Payables due after more than one year**	SoFP	**27,731**	**27,731**
168,914	**168,898**	**TOTAL PAYABLES**		**176,946**	**176,927**

Highland Health Board

NOTES TO THE ACCOUNTS for the Year Ended 31 March 2022

13a PROVISIONS – CONSOLIDATED AND BOARD

	Note	Pensions & similar obligations	Clinical & Medical Claims against NHS Board	Participation in CNORIS	Other (non Endowment)	2022 Total
		£000	£000	£000	£000	£000
At 1 April 2021		**10,346**	**17,763**	**32,391**	**347**	**60,847**
Arising during the year		155	15,183	1,672	153	17,163
Utilised during the year		(641)	(5,837)	(1,053)	(86)	(7,617)
Unwinding of discount		333	0	0	0	333
Reversed unutilised		(666)	(9,923)	0	(114)	(10,703)
At 31 March 2022	**2**	**9,527**	**17,186**	**33,010**	**300**	**60,023**

The amounts shown above in relation to Clinical & Medical Legal Claims against NHS Highland are stated gross and the amount of any expected reimbursements are separately disclosed as receivables in Note 9

Analysis of expected timing of discounted flows – to 31 March 2022

	Pensions & similar obligations	Clinical & Medical Claims against NHS Board	Participation in CNORIS	Other (non Endowment)	2022 Total
	£000	£000	£000	£000	£000
Payable in one year	1,336	4,725	8,234	300	14,595
Payable between 2-5 years	2,367	1,629	20,061	0	24,057
Payable between 6-10 years	2,411	2,651	1,707	0	6,769
Thereafter	3,413	8,181	3,008	0	14,602
Total as at 31 March 2022	**9,527**	**17,186**	**33,010**	**300**	**60,023**

NOTES TO THE ACCOUNTS for the Year Ended 31 March 2022

13a PROVISIONS – CONSOLIDATED AND BOARD, Contd

PROVISIONS – CONSOLIDATED AND BOARD (PRIOR YEAR)

	Pensions & similar obligations	Clinical & Medical Claims against NHS Board	Participation in CNORIS	Other (non Endowment)	2021 Total
	£000	£000	£000	£000	£000
At 1 April 2020	10,101	13,828	32,431	155	56,515
Arising during the year	534	5,498	1,922	294	8,248
Utilised during the year	(694)	(1,465)	(1,962)	(81)	(4,202)
Unwinding of discount	454	0	0	0	454
Reversed unutilised	(49)	(98)	0	(21)	(168)
At 31 March 2021	**10,346**	**17,763**	**32,391**	**347**	**60,847**

The amounts shown above in relation to Clinical & Medical Legal Claims against NHS Highland are stated gross and the amount of any expected reimbursements are separately disclosed as receivables in Note 9

Analysis of expected timing of discounted flows to 31 March 2021

	Note	Pensions & similar obligations	Clinical & Medical Claims against NHS Board	Participation in CNORIS	2Other (non Endowment)	2021 Total
		£000	£000	£000	£000	£000
Payable in one year		866	13,318	8,080	232	22,496
Payable between 2-5 years		2,885	1,746	19,685	115	24,431
Payable between 6-10 years		2,806	1,775	1,674	0	6,255
Thereafter		3,789	924	2,952	0	7,665
Total as at 31 March 2021		**10,346**	**17,763**	**32,391**	**347**	**60,847**

NOTES TO THE ACCOUNTS for the Year Ended 31 March 2022

13a PROVISIONS – CONSOLIDATED AND BOARD, Contd

Pensions and similar obligations

The Board meets the additional costs of benefits beyond the normal National Health Service Superannuation Scheme for Scotland benefits in respect of employees who retire early by paying the required amounts annually to the National Health Service Superannuation Scheme for Scotland over the period between early departure and normal retirement date. The Board provides for this in full when the early retirement programme becomes binding by establishing a provision for the estimated payments discounted by the Treasury discount rate of 0.10% in real terms. The Board expects expenditure to be charged to this provision for a period of up to 17 years. Please refer to Accounting policies for further details.

Clinical & Medical Legal Claims against NHS Boards

The Board holds a provision to meet costs of all outstanding and potential clinical and medical negligence claims. All legal claims notified to the Board are processed by the Scottish NHS Central Legal Office who will decide upon risk liability and likely outcome of each case. The provision contains sums for settlement awards, legal expenses and third party costs. Clinical and medical negligence cases lodged can be extremely complex. It is expected that expenditure will be charged to this provision in future years. The amounts disclosed are stated gross and the amount of any expected reimbursements are shown separately as debtors in the notes to the accounts. Please refer to Accounting policies for further details.

Other (non-endowment)

The Board has provided for Employers and Third Party claims by reviewing all outstanding and potential claims which the Board may be liable for. The Board has provided 100% for claims assessed as Category 3, 50% of all claims assessed as Category 2. The balance of Category 2 and all of Category 1 being disclosed as Contingent Liabilities in Note 14. The provision is based on an estimate of the possible cost together with adverse legal costs. Please refer to Accounting policies for further details.

Highland Health Board

NOTES TO THE ACCOUNTS for the Year Ended 31 March 2022

13b CLINICAL NEGLIGENCE AND OTHER RISKS INDEMNITY SCHEME (CNORIS)

2021 £000		Note	2022 £000
18,935	Provision recognising individual claims against the NHS Board as at 31 March	13a	20,033
(17,648)	Associated CNORIS receivable at 31 March	9	(19,549)
32,391	Provision recognising the NHS Board's liability from participating in the scheme at 31 March	13a	33,010
33,678	**Net Total Provision relating to CNORIS at 31 March**		**33,494**

The Clinical Negligence and Other Risks 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 £25k and any claims with a value less than this are met directly from within the board's own budgets. Participants, e.g. NHS board contribute to the CNORIS pool each financial year at a pre-agreed contribution rate based on the risks associated with their individual NHS board. If a claim is settled the board will be reimbursed by the scheme for the value of the settlement, less a £25k "excess" fee. The scheme allows for the risk associated with any large or late in the financial year legal claims to be managed and reduces the level of volatility that individual boards are exposed to.

When a legal claim is made against an individual board, the board will assess whether a provision or contingent liability for that legal claim is required. If a provision is required then the board will also create an associate receivable recognising reimbursement from the scheme if the legal claim settles. The provision and associated receivable are shown in the first two lines above. The receivable has been netted off against the provision to reflect reimbursement from the scheme.

As a result of participation in the scheme, 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 board's share of the total CNORIS liability of NHSScotland has been made and this is reflected in the third line above.

Therefore, there are two related but distinct provisions required as a result of participation in the scheme. Both these provisions, as well as the associated receivable have been shown in the note above to aid the reader's understanding of CNORIS.

Further information on the scheme can be found here

NOTES TO THE ACCOUNTS for the Year Ended 31 March 2022

14 CONTINGENT LIABILITIES

The following contingent liabilities have not been provided for in the Accounts.

2021 £000		2022 £000
	Nature	
643	Clinical and medical compensation payments	2,378
115	Employer's liability	119
68	Third party liability	50
826	**TOTAL CONTINGENT LIABILITIES**	**2,547**

2021 £000	**CONTINGENT ASSETS**	2022 £000
408	Clinical and medical compensation payments	1,988
35	Employer's liability	35
28	Third party	15
471		**2,038**

15 EVENTS AFTER THE END OF THE REPORTING YEAR

There are no events after the end of reporting period to disclose.

16 COMMITMENTS

Capital Commitments

The Board has the following capital commitments which have not been provided for in the Accounts.

2021 £000		Property, plant & equipment 2022 £000
	Contracted	
4,402	Mid Argyll PFI Lifecycle costs	4,124
2,682	Easter Ross PFI Lifecycle Costs	2,519
7,975	Skye, B&S Hospital HUB Projects	0
31,604	National Treatment Centre (Wad ECC)	12,900
0	Increased hospital / community capacity	5,630
46,663	**Total**	**25,173**
	Authorised but not Contracted	
1,591	Skye, B+S Hospital Bundle - equipping	0
1,759	Grantown Health Centre Refurbishment	2,500
2,132	Portree Spoke Reconfiguration	2,820
29,300	Belford Hospital Replacement	42,750
0	Rolling Replacement Programmes	0
2,797	Radiotherapy	5,357
6,300	Increased hospital / community capacity	0
0	Caithness Redesign Project	42,750
43,879	**Total**	**96,177**

NOTES TO THE ACCOUNTS for the Year Ended 31 March 2022

17 COMMITMENTS UNDER LEASES

Operating Leases
Total future minimum lease payments under operating leases are given in the table below for each of the following periods:

Obligations under operating leases comprise:

2021 £000		2022 £000
	Buildings	
2,154	Not later than one year	3,211
1,963	Later than one year, not later than 2 years	2,879
4,467	Later than two years, not later than five years	7,832
10,375	Later than five years	8,066
	Other	
1,610	Not later than one year	3,376
1,230	Later than one year, not later than two years	2,278
1,138	Later than two years, not later than five years	4,668
0	Later than five years	3,604
	Amounts charged to Operating Costs in the year were:	
3,142	Hire of equipment (including vehicles)	3,738
4,204	Other operating leases	3,653
7,346	**Total**	**7,391**

Finance Leases

Total future minimum lease payments under finance leases are given in the table below for the each of the following periods.

Obligations under Finance leases comprise:

2021 £000		2022 £000
	Buildings	
383	Rentals due within one year	383
383	Rentals due between one and two years (inclusive)	384
1,012	Rentals due between two and five years (inclusive)	710
273	Rentals due after five years	218
2,051		1,695
(505)	Less interest element	(378)
1,546		**1,317**
	This total net obligation under finance leases is analysed in Note 12 (Trade and Other Payables)	
	Aggregate Rentals Receivable in the year	
870	Total of finance & operating leases	**811**

Highland Health Board

NOTES TO THE ACCOUNTS for the Year Ended 31 March 2022

18 COMMITMENTS UNDER PFI CONTRACTS – ON BALANCE SHEET

The Board has entered into the following PFI contracts:

Total obligations under on-balance sheet PFI/PPP/Hub contracts for the following periods comprises:

2021 £000	Gross Minimum Lease Payments	Note	New Craig's £000	Easter Ross £000	Mid Argyll £000	Tain HC HUB £000	2022 Total £000
4,187	Rentals due within 1 year		1,922	622	1,228	417	4,189
4,189	Due within 1 to 2 years		1,922	622	1,229	419	4,192
11,440	Due within 2 to 5 years		2,700	1,865	3,686	1,272	9,523
20,731	Due after 5 years		0	1,779	11,348	5,327	18,454
40,547	**Total**		6,545	4,888	17,491	7,435	36,359
	***Less* Interest Element**						
(1,992)	Rentals due within 1 year		(646)	(196)	(603)	(329)	(1,774)
(1,775)	Due within 1 to 2 years		(462)	(175)	(573)	(321)	(1,531)
(3,783)	Due within 2 to 5 years		(304)	(388)	(1,522)	(908)	(3,122)
(5,547)	Due after 5 years		0	(155)	(2,372)	(2,150)	(4,677)
(13,096)	**Total**		(1,412)	(914)	(5,070)	(3,708)	(11,104)
	Present value of minimum lease payments						
2,195	Rentals due within 1 year	12	1,276	426	625	88	2,415
2,415	Due within 1 to 2 years	12	1,460	447	656	98	2,661
7,657	Due within 2 to 5 years	12	2,396	1,477	2,164	364	6,401
15,184	Due after 5 years	12	0	1,624	8,976	3,177	13,777
27,451	**Total**		5,133	3,974	12,421	3,727	25,255
	Service elements due in further periods						
4,637	Rentals due within 1 year		2,689	787	1,283	85	4,844
4,699	Due within 1 to 2 years		2,689	868	1,421	86	5,064
13,346	Due within 2 to 5 years		6,050	3,090	4,866	243	14,249
26,336	Due after 5 years		0	3,845	20,909	790	25,544
49,018	**Total**		11,428	8,590	28,479	1,204	49,701
76,470	**Total Commitments**		**16,561**	**12,564**	**40,900**	**4,931**	**74,956**

Amounts charged to the Statement of comprehensive net expenditure in respect of on balance sheet PFI transactions comprises;

2021 £000		Note	2022 £000
1,819	Interest charges	2	1,981
4,865	Service Charges		4,973
2,000	Principal repayment		2,195
17	Other Charges		19
8,701	**Total**		**9,168**
17	Contingent Rents – (including other charges)		19

NOTES TO THE ACCOUNTS for the Year Ended 31 March 2022

19 PENSION COSTS

IAS 19 Multi-employer plans

a) The Board participates in the NHS Pension Scheme (Scotland). The scheme is an unfunded statutory public service pension scheme with benefits underwritten by the UK Government. The scheme is financed by payments from employers and from those current employees who are members of the scheme and paying contributions at progressively higher marginal rates based on pensionable pay, as specified in the regulations. The rate of employer contributions is set with reference to a funding valuation undertaken by the scheme actuary. The last four-yearly valuation was undertaken as at 31 March 2016. This valuation informed an employer contribution rate from 1 April 2020 of 20.9% of pensionable pay and an anticipated yield of 9.6% employees contributions.

(b) The Board has no liability for other employers' obligations to the multi-employer scheme.

(c) As the scheme is unfunded there can be no deficit or surplus to distribute on the wind-up of the scheme or withdrawal from the scheme.

(d)

(i) The scheme is an unfunded multi-employer defined benefit scheme.

(ii) It is accepted that the scheme can be treated for accounting purposes as a defined contribution scheme in circumstances where the Board is unable to identify its share of the underlying assets and liabilities of the scheme.

(iii) The employer contribution rate for the period from 1 April 2021 is 20.9% of pensionable pay. The employee rate applied is variable and is anticipated to provide a yield of 9.6% of pensionable pay.

(iv) While a valuation was carried out as at 31 March 2016, work on the cost cap valuation was suspended by the UK Government following the decision by the Court of Appeal (McCloud (Judiciary scheme)/Sergeant (Firefighters' Scheme) cases) that the transitional protections provided as part of the 2015 reforms unlawfully discriminated on the grounds of age. Following consultation and an announcement in February 2021 on proposals to remedy the discrimination, the UK Government confirmed that the cost control element of the 2016 valuations could be completed. The UK Government has also asked the Government Actuary to review whether, and to what extent, the cost control mechanism is meeting its original objectives. The 2020 actuarial valuations will take the report's findings into account. The interim report is complete (restricted) and is currently being finalised with a consultation. Alongside these announcements, the UK Government confirmed that current employer contribution rates would stay in force until 1 April 2024.

(v) The Board's level of participation in the scheme is 4.8% based on the proportion of employer contributions paid in 2020-21.

Description of schemes

The new NHS Pension Scheme (Scotland) 2015

From 1 April 2015 the NHS Pension Scheme (Scotland) 2015 was introduced. This scheme is a Career Average Re-valued Earnings (CARE) scheme. Members will accrue 1/54 of their pay as pension for each year they are a member of the scheme. The accrued pension is re-valued each year at an above inflation rate to maintain its buying power. This is currently 1.5% above increases to the Consumer Prices Index (CPI). This continues until the member leaves the scheme or retires. In 2020-21 members paid tiered contribution rates ranging from 5.2% to 14.7% of pensionable earnings. The normal pension age (NPA) is the same as the state Pension age. Members can take their benefits earlier but there will be a deduction for early payment.

NOTES TO THE ACCOUNTS for the Year Ended 31 March 2022

The existing NHS Superannuation Scheme (Scotland)

This scheme closed to new joiners on 31 March 2015, but was challenged in court and subsequently extended to 31 March 2022. Members will have the option to retain these additional years in the old scheme or transfer to the new scheme on retirement. Any benefits earned in either NHS 1995 or NHS 2008 sections are protected and will be paid at the section's normal pension age using final pensionable pay when members leave or retire. Some members who were close to retirement when the NHS 2015 scheme launched will continue to earn benefits in their current section. This may affect members who were paying into the scheme on 1 April 2012 and were within 10 years of their normal retirement age. Some members who were close to retirement but did not qualify for full protection will remain in their current section beyond 1 April 2015 and join the 2015 scheme at a later date.

All other members automatically joined the NHS 2015 scheme on 1 April 2015. Further information is available on the Scottish Public Pensions Agency (SPPA) web site at Scottish Public Pensions Agency home page | SPPA

National Employment Savings Trust (NEST)

The Pensions Act 2008 and 2011 Automatic Enrolment regulations required all employers to enrol workers meeting certain criteria into a pension scheme and pay contributions toward their retirement. For those staff not entitled to join the NHS Superannuation Scheme (Scotland), the Board utilised an alternative pension scheme called NEST to fulfil its Automatic Enrolment obligations.

NEST is a defined contribution pension scheme established by law to support the introduction of Auto Enrolment. Contributions are taken from qualifying earnings, which are currently from £6,240 up to £50,270, but will be reviewed every year by the government. The initial employee contribution is 5% of qualifying earnings, with an employer contribution of 3%. This will increase in stages to meet levels set by government.

	Employee Contribution	Employer Contribution	Total Contribution
October 2012 - 5 April 2018	1%	1%	2%
6 April 2018 - 5 April 2019	3%	2%	5%
6 April 2019 onwards	5%	3%	8%

Pension members can choose to let NEST manage their retirement fund or can take control themselves and alter contribution levels and switch between different funds. If pension members leave the Board they can continue to pay into NEST.

NEST Pension members can take money out of NEST at any time from age 55. If suffering from serious ill health or incapable of working due to illness, members can request to take money out of NEST early. They can take the entire retirement fund as cash; use it to buy a retirement income or a combination. Additionally, members can transfer their NEST retirement fund to another scheme.

NEST is run by NEST Corporation, a trustee body which is a non-departmental public body operating at arm's length from government and is accountable to Parliament through the Department for Work and Pensions.

	2022 £000	**2021 £000**
Pension cost charge for the year	65,973	61,141
Additional costs arising from early retirement	126	
Pension cost in year of staff transferred from Highland Council	1,457	3,263
Provisions/Liabilities/Pre-payments included in the SoFP	5,607	1,636

NOTES TO THE ACCOUNTS for the Year Ended 31 March 2022

PENSION COSTS FOR STAFF TRANSFERRED FROM HIGHLAND COUNCIL

As part of the terms and conditions of employment for the staff transferred from The Highland Council, the Board participates in the Local Government Pension Scheme administered by The Highland Council. This is a funded scheme, meaning that the authority and employees pay contributions into a fund, calculated at a level intended to balance the pension liabilities with investment assets.

The Fund is constituted under legislation governing the Local Government Superannuation Scheme – details are contained in the 2010 regulations. The Highland Council is required to publish the Pension Fund annual report which is available at www.highland.gov.uk or from The Highland Council, Glen Urquhart Road, Inverness.

NHS Highland recognises the costs of these retirement benefits in the Statement of Net Comprehensive expenditure when they are earned by these employees, rather than when the benefits are eventually paid as pensions.

The Highland Council recognises the liability of the Pension Fund at 31 March 2012 attributable to these NHS Highland staff in the The Highland Council accounts. NHS Highland recognises the gain in the Fund for the year from 1 April 2021 to 31 March 2022 of £5.067m, giving a total to 31st March 2022 of £32.639m (total to 31st March 2021 of £37.706m). This is included in two parts in NHS Highland's accounts:-

a) £37.395m of realised deficit in SOCNE which has been covered by funding from Scottish Government and

b) £4.756m of unrealised gains due to actuarial assumptions which is recorded as other Comprehensive Net Expenditure and offset against Reserves in the SoFP.

The deficit on the fund will be made good by increased contributions over the remaining working life of employees as assessed by the scheme's actuary. NHS Highland represents 4.8% of the scheme participants.

The charge to the Statement of Comprehensive Net Expenditure consists of:

	2022 £000	2021 £000
Current Service cost	7,723	5,825
Interest Cost	2,123	1,749
Interest Income	(1,322)	(1,216)
IAS 19 charge to service costs	**8,524**	**6,358**
Financial Assumptions Gain / (loss)	10,674	(12,598)
Gain / (loss) through other comprehensive net expenditure	10,674	**(12,598)**

The current assets and liabilities are made up of:-

Present Value of the Scheme Liabilities		
Opening defined benefit obligation	102,644	73,586
Current Service Cost	7,723	5,825
Interest Cost	2,123	1,749
Change in financial assumptions	(7,598)	22,063
Estimated benefits paid	(1,458)	(1,737)
Changes in demographic assumptions	(546)	247
Other experience	210	(41)
Contributions by scheme participants	941	952
Closing Value	104,039	102,644

NOTES TO THE ACCOUNTS for the Year Ended 31 March 2022

Fair Value of the Scheme Assets		
Opening Fair Value of scheme assets	64,938	51,741
Expected return on scheme assets	2,740	12,559
Interest Income	1,322	1,216
Contributions by employer	2,917	3,095
Contributions by Scheme participants	941	952
Other Experience	0	(2,888)
Estimated benefits paid (net of transfers in)	(1,458)	(1,737)
Closing value	71,400	64,938

The expected return on fund assets is determined by considering the expected returns available on the assets underlying the current investment policy. Expected yields on fixed interest investments are based on gross redemption yields as at the SoFP date. Expected returns on equity investments reflect long-term real rates of return experienced in the respective markets.

The total contributions expected to be made to The Highland Council Pension Scheme by NHS Highland in the year to 31 March 2023 is £2.917m.

Basis for estimating assets and liabilities of the Pension Scheme

Liabilities have been assessed on an actuarial basis using the projected unit credit method, an estimate of the pensions that will be payable in future years dependent on assumptions about mortality rates, salary levels, etc. The Local Government Pension Scheme has been assessed by Hymans Robertson LLP, an independent firm of actuaries, estimates for The Highland Council Pension Fund being based on the latest full valuation of the scheme as at 31 March 2021.

The principal actuarial assumptions adopted as at 31 March 2022 are as follows:

		2022	**2021**
(a)	Long term expected rate of return on assets in the scheme	3.2%	2.0%
(b)	Life expectancy from age 65 (years)		
	Retiring today:		
	Males	20.8	20.9
	Females	23.3	23.5
	Retiring in 20 years:		
	Males	22.0	22.3
	Females	25.3	25.5
(c)	Financial assumptions		
	Rate of increase in salaries	4.00%	3.65%
	Rate of increase in pensions (CPI)	3.2%	2.85%
	Rate of discounting scheme liabilities	2.7%	2.0%
	Take up of option to convert annual pension into retirement lump sum	50%	50%

(d) The Local Government Pension Scheme's assets consist of the following categories by proportion of the total assets held

Securities	49%	53%
Debt Securities	12%	0%
Private Equity	6%	7%
Real Estate	10%	8%
Investment Funds & Unit Trusts	18%	24%
Cash	5%	8%
Total	100%	100%

20 RETROSPECTIVE RESTATEMENTS

There have been no retrospective statements recognised in these accounts

21 RESTATED PRIMARY STATEMENTS

There have been no restated primary statements in these accounts

NOTES TO THE ACCOUNTS for the Year Ended 31 March 2022

22 FINANCIAL INSTRUMENTS

22a Financial Assets

CONSOLIDATED At 31 March 2022	Notes	Financial Assets at amortised cost £000	Financial Assets at fair value through profit/loss £000	Total £000
Assets per SoFP				
Investments		0	8,696	8,696
Trade and other receivables excluding prepayments, reimbursements of provisions and VAT recoverable.		37,660	0	37,660
Cash and cash equivalents		935	0	935
		38,595	**8,696**	**47,291**

BOARD At 31 March 2022	Notes	Financial Assets at amortised cost £000	Financial Assets at fair value through profit/loss £000	Total £000
Assets per SoFP				
Investments		0	102	102
Trade and other receivables excluding prepayments, reimbursements of provisions and VAT recoverable.		37,771	0	37,771
Cash and cash equivalents		15	0	15
		37,786	**102**	**37,888**

CONSOLIDATED (Prior Year) At 31 March 2021	Notes	Financial Assets at amortised cost £000	Financial Assets at fair value through profit/loss £000	Total £000
Assets per SoFP				
Investments	10		8,497	8,497
Trade and other receivables excluding prepayments, reimbursements of provisions and VAT recoverable	9	33,465		33,465
Cash and cash equivalents	11	971		971
		34,436	**8,497**	**42,933**

BOARD (Prior Year) At 31 March 2021	Notes	Financial Assets at amortised cost £000	Financial Assets at fair value through profit/loss £000	Total £000
Assets per SoFP				
Investments	10		106	106
Trade and other receivables excluding prepayments, reimbursements of provisions and VAT recoverable	9	33,561		33,561
Cash and cash equivalents	11	88		88
		33,649	**106**	**33,755**

22 Financial Instruments (cont'd)

Financial Liabilities

CONSOLIDATED at 31 March 2022	Note	Liabilities at Fair Value through profit and loss £000	Financial liabilities at amortised cost £000	Total £000
Liabilities per SoFP				
Finance lease liabilities			1,317	1,317
PFI Liabilities			25,255	25,255
Trade and other payables excluding statutory liabilities (VAT and income tax and social security), deferred income and superannuation recoverable.			118,461	118,461
			145,033	**145,033**

BOARD at 31 March 2022	Note	£000	£000	£000
Liabilities per SoFP				
Finance lease liabilities			1,317	1,317
PFI Liabilities			25,255	25,255
Trade and other payables excluding statutory liabilities (VAT and income tax and social security), deferred income and superannuation recoverable.			118,442	118,442
			145,014	**145,014**

CONSOLIDATED (Prior Year) at 31 March 2021	Note	£000	£000	£000
Finance lease liabilities			1,546	1,546
PFI Liabilities	12		27,451	27,451
Trade and other payables excluding statutory liabilities (VAT and income tax and social security), deferred income and superannuation	12		89,285	89,285
		0	**118,282**	**118,282**

BOARD (Prior Year) at 31 March 2021	Note	£000	£000	£000
Finance lease liabilities			1,546	1,564
PFI Liabilities	12		27,451	27,451
Trade and other payables excluding statutory liabilities (VAT and income tax and social security), deferred income and superannuation	12		89,269	89,269
		0	**118,266**	**118,266**

22b Financial Risk Factors

Exposure to Risk

The NHS Board's activities expose it to a variety of financial risks:

Credit risk - the possibility that other parties might fail to pay amounts due.

Liquidity risk - the possibility that the NHS Board might not have funds available to meet its commitments to make payments.

Market risk - the possibility that financial loss might arise as a result of changes in such measures as interest rates, stock market movements or foreign exchange rates.

Because of the largely non-trading nature of its activities and the way in which government departments are financed, the NHS Board is not exposed to the degree of financial risk faced by business entities.

a) Credit Risk

Credit risk arises from cash and cash equivalents, deposits with banks and other institutions, as well as credit exposures to customers, including outstanding receivables and committed transactions.

For banks and other institutions, only independently rated parties with a minimum rating of 'A' are accepted.

Customers are assessed, taking into account their financial position, past experience and other factors, with individual credit limits being set in accordance with internal ratings in accordance with parameters set by the NHS Board.

The utilisation of credit limits is regularly monitored.

No credit limits were exceeded during the reporting period and no losses are expected from non-performance by any counterparties in relation to deposits.

b) Liquidity Risk

The Scottish Parliament makes provision for the use of resources by the NHS Board for revenue and capital purposes in a Budget Act for each financial year. Resources and accruing resources may be used only for the purposes specified and up to the amounts specified in the Budget Act. The Act also specifies an overall cash authorisation to operate for the financial year. The NHS Board is not therefore exposed to significant liquidity risks.

The table below analyses the financial liabilities into relevant maturity groupings based on the remaining period at the SoFP to contractual maturity date. The amounts disclosed in the table are the contractual undiscounted cash flows. Balances due within 12 months equal their carrying balances as the impact of discounting is not significant.

	Less than 1 year	Between 1 and 2 years	Between 2 and 5 years	Over 5 years
at 31 March 2022	**£000**	**£000**	**£000**	**£000**
PFI Liabilities	4,189	4,192	9,523	18,454
Finance lease liabilities	383	384	710	218
Trade and other payables exc statutory liabilities				
Total	**4,572**	**4,576**	**10,233**	**18,672**

at 31 March 2021	**£000**	**£000**	**£000**	**£000**
PFI Liabilities	4,187	4,189	11,440	20,731
Finance lease liabilities	383	383	1,001	273
Trade and other payables exc statutory liabilities				
Total	**4,570**	**4,572**	**12,441**	**21,004**

c) Market Risk

The NHS Board has no powers to borrow or invest surplus funds. Financial assets and liabilities are generated by day-to-day operational activities and are not held to manage the risks facing the NHS Board in undertaking its activities.

i) Cash flow and fair value interest rate risk
The NHS Board has no significant interest bearing assets or liabilities and as such income and expenditure cash flows are substantially independent of changes in market interest rates.

ii) Foreign Currency Risk
The NHS Board is not exposed to foreign exchange rates.

iii) Price risk
The NHS Board is not exposed to equity security price risk.

c FAIR VALUE ESTIMATION

The fair value of financial instruments that are not traded in an active market (for example, over the counter derivatives) is determined using valuation techniques.

The carrying value net of expected credit loss of trade receivables & payables are expected to approximate their fair value

The fair value of financial liabilities for disclosure purposes is estimated by discounting the future contractual cash flows at the current HM Treasury interest rate that is available for similar financial instruments.

23 DERIVATIVE FINANCIAL INSTRUMENTS

The Board has no transactions of this type.

24 RELATED PARTY TRANSACTIONS

The Board enters into transactions with other Scottish Government and United Kingdom Government agencies and publicly funded bodies (such as Councils and educational institutions) in the ordinary course of its operations. These transactions take place at arms length. Scottish Ministers issue instructions and guidance on special transactions between publicly funded bodies in areas such as property transfers and joint venture investments.

NHS Highland enters into significant transactions with other Scottish Boards including:

NHS Grampian
NHS GGC
NHS NSS
NES
NHS National Waiting Times Centre Board (Golden Jubilee NWTC)
Western Isles
Lothian
Tayside.

From 1 April 2012, The Highland Council and NHS Highland integrated health and social care services. Under the partnership agreement effective from that date, NHS Highland is the lead agency for integrated adult services and The Highland Council for the delivery of integrated children's services. From 1 April 2012, NHS Highland and its adult social care staff contributed to the Pension Fund run by The Highland Council which provides pensions for the social care staff of NHS Highland

	2022 £'000	2021 £'000
Income	105,328	100,901
Expenditure	11,652	11,500
Payables	14,775	3,123
Receivables	16,480	22,233

The integration of adult health and social services resulted in the creation of the Argyll and Bute Health and Social Care Partnership (IJB) established between Highland NHS Board and the Argyll

and Bute Council. The voting members of the IJB are appointed through nomination by NHS Highland and Argyll and Bute Council. The voting membership of the IJB Board is split equally between both organisations. Nomination of the IJB Chair and Vice Chair post holders alternates between a councillor and a health board representative.

	2022 £'000	2021 £'000
Income	239,365	230,529
Expenditure	269,993	254,245
Payables	19,048	4,197

Senior officers have control over the Board's financial and operating policies. The total renumeration to senior officers is shown in the Remuneration Report. Officers have the responsibility to adhere to a Code of Conduct, which requires them to declare an interest in matters that directly may influence or thought to influence, their judgment or decisions taken during their work. In terms of any related parties, officers with declarations of interest did not take part in any discussion or decisions relating to transactions with these parties. The full list of Directors & senior staff declarations of interest are publicly available on NHS Highland's website**.**

NHS Highland Endowments

The trustees of the Highland Health Board Endowment fund are all members of NHS Highland Board. As a result the Endowment fund accounts are consolidated with the NHS Highland Accounts. All trustees are listed in the remuneration report on P44.

25 THIRD PARTY ASSETS

Third Party Assets managed by the Board consist of balances on Patients' and Clients' Private Funds Accounts.

These are not departmental assets and are not included in the accounts. The assets held at the reporting period date to which it was practical to ascribe monetary values comprised monetary assets, such as bank balances and monies on deposit, and listed securities. They are set out in the table immediately below.

	2021 £000	Gross Inflows £000	Gross Outflows £000	2022 £000
Monetary amounts such as bank balances and monies on deposit	2,409	3,737	(3,381)	2,765
Total Monetary Assets	**2,409**	**3,737**	**(3,381)**	**2,765**

26a CONSOLIDATED STATEMENT OF COMPREHENSIVE NET EXPENDITURE

Consolidated 2021 £000		Note	Board 2022 £000	Endowment 2022 £000	Intra Group adjustment 2022 £000	IJB 2022 £000	Consolidated 2022 £000
	Total Income and Expenditure						
468,510	Staff Costs	3	492,584	0	0	0	492,584
	Other operating expenditure	3					
106,343	Independent Primary Care Services		111,321	0	0	0	111,321
138,890	Drugs and medical supplies		154,052	0	0	0	154,052
607,882	Other health care expenditure		645,276	787	(107)	0	645,956
1,324,888	**Gross expenditure for the year**		**1,403,233**	**787**	**(107)**	**0**	**1,403,913**
(400,711)	Less: Operating Income	4	(427,660)	(752)	107	0	(428,305)
(3,293)	Associates & joint ventures accounted for on an equity basis		0	0	0	(7,332)	(7,332)
920,884	**Net Expenditure**		**975,573**	**35**	**0**	**(7,332)**	**968,276**

Other health care expenditure and income relates to the consolidation of the Endowment Accounts.

Joint Ventures accounted for on an equity basis discloses the Board's share of any current year surplus or deficit for each integration Joint Board.

26b CONSOLIDATED STATEMENT OF FINANCIAL POSITION

Consolidated 2021 £000		Note	Board 2022 £000	Endowment 2022 £000	Intra Group adjustment 2022 £000	IJB 2022 £000	Consolidated 2022 £000
	Non-current Assets:						
396,751	Property, plant and equipment	SoFP	461,718	0	0	0	461,718
1,743	Intangible assets	SoFP	1,736	0	0	0	1,736
	Financial assets:						
8,497	Available for sale financial assets	SoFP	102	8,594	0	0	8,696
3,293	Investments in associates and Joint ventures		0	0	0	10,625	10,625
11,300	Trade and other receivables	SoFP	26,978	0	0	0	26,978
421,584	**Total non-current assets**		**490,534**	**8,594**	**0**	**10,625**	**509,753**
	Current Assets:						
6,406	Inventories	SoFP	7,236	0	0	0	7,236
	Financial assets:						
52,628	Trade and other receivables	SoFP	45,488	4	(115)	0	45,377
971	Cash and cash equivalents	SoFP	15	920	0	0	935
60,005	**Total current assets**		**52,739**	**924**	**(115)**	**0**	**53,548**
481,589	**Total Assets**		**543,273**	**9,518**	**(115)**	**10,625**	**563,301**
	Current liabilities						
(22,496)	Provisions	SoFP	(14,595)	0	0	0	(14,595)
	Financial liabilities:						
(136,430)	Trade and other payables	SoFP	(149,195)	(134)	115	0	(149,214)
(158,926)	**Total current liabilities**		**(163,790)**	**(134)**	**115**	**0**	**(163,809)**
322,663	**Non-current assets plus / less net current assets / liabilities**		**379,483**	**9,384**	**0**	**10,625**	**399,492**
	Non-current liabilities						
(38,351)	Provisions	SoFP	(45,428)	0	0	0	(45,428)
	Financial liabilities:						
(32,484)	Trade and other payables	SoFP	(27,731)	0	0	0	(27,731)
(70,835)	**Total non-current liabilities**		**(73,159)**	**0**	**0**	**0**	**(73,159)**
251,828	**Assets less liabilities**		**306,323**	**9,384**	**0**	**10,625**	**326,332**
	Taxpayers Equity						
116,048	General Fund	SoFP	145,438	0	0	0	145,438
97,455	Revaluation reserve	SoFP	118,734	0	0	0	118,734
25,870	Other reserves	SoFP	42,151	0	0	0	42,151
3,293	Other reserves – Joint ventures	SoFP	0	0	0	10,625	10,625
9,162	Funds Held on Trust	SoFP	0	9,384	0	0	9,384
251,828	**Total taxpayers' equity**		**306,323**	**9,384**	**0**	**10,625**	**326,332**

NOTES TO THE ACCOUNTS for the Year Ended 31 March 2022

26c CONSOLIDATED STATEMENT OF CASHFLOWS

Consolidated		Board	Endowment	Intra group adjustment	IJB	Consolidated
2021 £000		2022 £000	2022 £000	2022 £000	2022 £000	2022 £000
	Cash flows from operating activities					
(920,884)	Net operating expenditure	(975,573)	(35)	0	7,332	(968,276)
11,541	Adjustments for non-cash transactions	37,555	0	0	(7,332)	30,223
2,787	Add back: interest payable recognised in net operating expenditure	2,465	0	0	0	2,465
(30)	Deduct: Interest receivable recognised in net operating expenditure	(11)	0	0	0	(11)
54,157	Movements in working capital	(8,947)	15	0	0	(8,932)
(852,429)	**Net cash outflow from operating activities**	**(944,511)**	**(20)**	**0**	**0**	**(944,531)**
	Cash flows from investing activities					
(54,984)	Purchase of property, plant and equipment	(54,879)	0	0	0	(54,879)
(396)	Purchase of intangible assets	(672)	0	0	0	(672)
(561)	Investment additions	0	(119)	0	0	(119)
	Transfer of assets to/(form) other NHS bodies	0	0	0	0	0
108	Proceeds of disposal of property, plant and equipment	139	0	0	0	139
403	Receipts from sale of investments	0	174	0	0	174
30	Interest and dividends received	11	0	0	0	11
(55,400)	**Net cash outflow from investing activities**	**(55,401)**	**55**	**0**	**0**	**(55,346)**
	Cash flows from financing activities					
912,692	Funding	1,004,819	0	0	0	1,004,819
(935)	Movement in general fund working capital	(88)	0	0	0	(88)
911,757	Cash drawn down	1,004,731	0	0	0	1,004,731
(2,180)	Capital element of payments in respect of finance leases and on-balance sheet PFI contracts	(2,425)	0	0	0	(2,425)
(454)	Interest paid	(333)	0	0	0	(333)
(2,333)	Interest element of finance leases and on-balance sheet PFI/PPP contracts	(2,132)	0	0	0	(2,132)
906,790	**Net Financing**	**999,841**	**0**	**0**	**0**	**999,841**
(1,039)	**Net increase / (decrease) in cash and cash equivalents in the period**	(71)	35	0	0	(36)
2,010	**Cash and cash equivalents at the beginning of the period**	86	885	0	0	971
971	**Cash and cash equivalents at the end of the period**	**15**	**920**	**0**	**0**	**935**
	Reconciliation of net cash flow to movement in net debt/cash					
(1,039)	Increase / (decrease) in cash in year	(71)	35	0	0	(36)
2,010	Net cash at 1 April	86	885	0	0	971
971	**Net cash at 31 March**	**15**	**920**	**0**	**0**	**935**

DIRECTIONS BY THE SCOTTISH MINISTERS

The Scottish Ministers, in exercise of their functions under section 86(1) and (3) of the National Health Service (Scotland) Act 1978, in relation to the functions of Health Boards in that section which apply to NHS Highland by virtue of that Act, and all other powers enabling them to do so, hereby DIRECT that:

1. NHS Highland must prepare a statement of accounts for each financial year in accordance with the accounting principles and disclosure requirements set out in the edition of the Government Financial Reporting Manual which is applicable for the financial year for which the statement of accounts is prepared.

2. In preparing a statement of accounts in accordance with paragraph 1, NHS Highland must use the NHS Highland Annual Accounts template which is applicable for the financial year for which the statement of accounts is prepared.

3. In preparing a statement of accounts in accordance with paragraph 1, NHS Highland must adhere to any supplementary accounting requirements set out in the following documents which are applicable for the financial year for which the statement of accounts is prepared –

   (a) The NHS Scotland Capital Accounting Manual,

   (b) The Manual for the Annual Report and Accounts of NHS Boards and for Scottish Financial Returns, and

   (c) The Scottish Public Finance Manual.

4. A statement of accounts prepared by NHS Highland in accordance with paragraphs 1, 2 and 3, must give a true and fair view of the income and expenditure and cash flows for that financial year, and of the state of affairs as at the end of the financial year.

5. NHS Highland must attach these directions as an appendix to the statement of accounts which it prepares for each financial year.

6. In these Directions –

   "financial year" has the same meaning as that given by Schedule 1 of the Interpretation Act 1978,

   "Government Financial Reporting Manual" means the technical accounting guide for the preparation of financial statements issued by HM Treasury,

   "Manual for the Annual Report and Accounts of NHS Boards and for Scottish Financial Returns" means the guidance on preparing annual accounts issued to Health Boards by the Scottish Ministers,

   "NHS Act 1978" means the National Health Service (Scotland) Act 1978 (c. 29),

   "NHS Scotland Capital Accounting Manual" means the guidance on the application of accounting standards and practice to capital accounting transactions in the NHS issued by the Scottish Ministers,

NHS Highland is a Health Board established under section 2(1) of the National Health Service (Scotland) Act 1978

"NHS Highland Annual Accounts template" means the Excel spreadsheet issued to NHS Highland by the Scottish Ministers as a template for their statement of accounts, and

"Scottish Public Finance Manual" means the guidance on proper handling and reporting of public funds issued by the Scottish Ministers.

7. Any expressions or definitions, where relevant and unless otherwise specified, take the meaning which they have in section 108 of the NHS Act 1978.

8. This Direction will come into force on the day after the day on which it is signed.

9. This Direction will remain in force until such time that it is varied, amended or revoked by a further Direction of the Scottish Ministers under section 86 of the NHS Act 1978.

Signed by the authority of the Scottish Ministers

Dated 22 March 2022