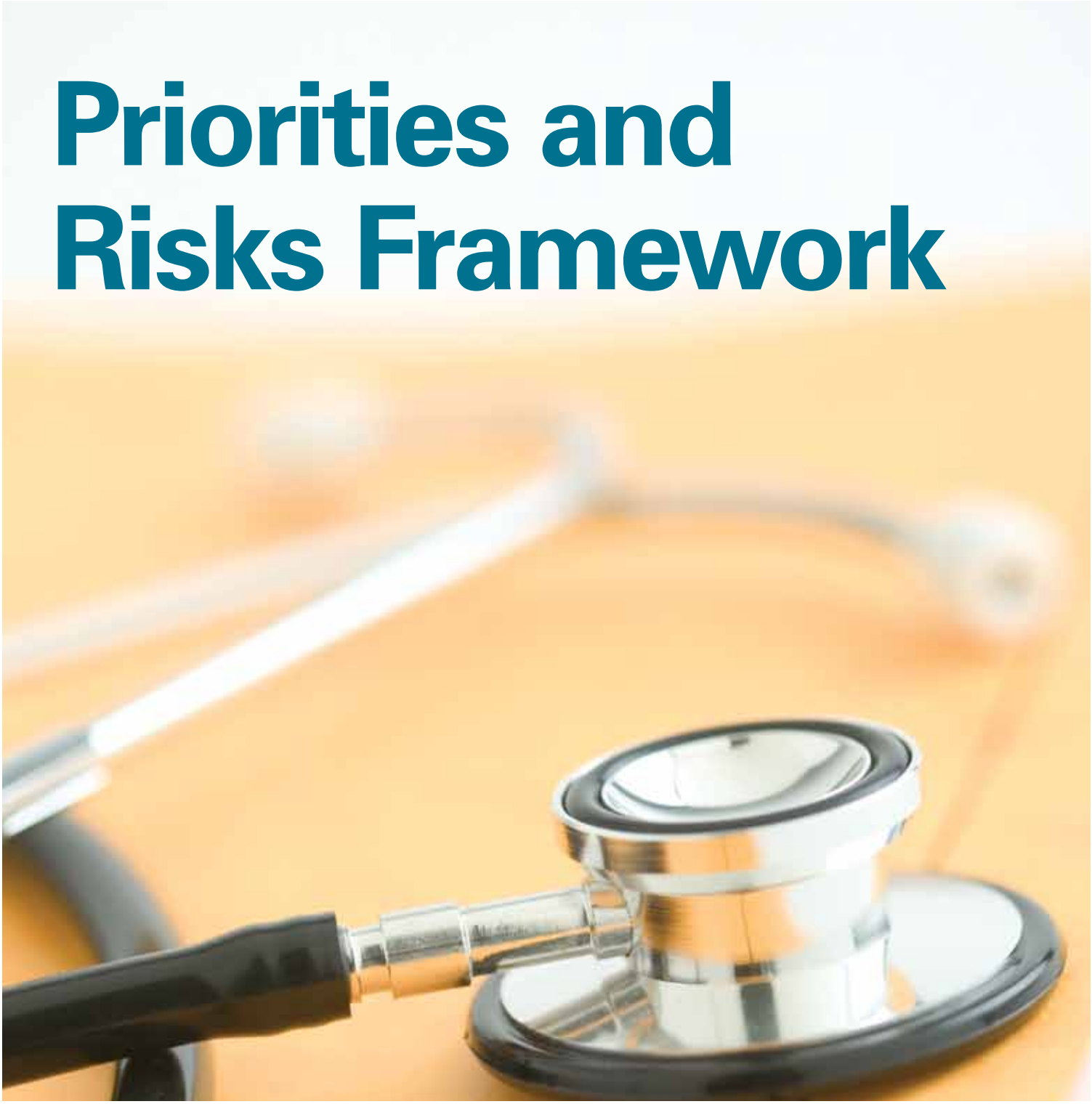
Priorities and Risks Framework



AUDIT SCOTLAND

A national planning tool for 2011/12 NHSScotland audits
November 2011

Auditor General for Scotland

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- government agencies, eg the Scottish Prison Service, Historic Scotland
- NHS bodies
- further education colleges
- Scottish Water
- NDPBs and others, eg Scottish Enterprise.

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

Contents

Introduction

Context

1. The Scottish healthcare environment has continued to evolve since we issued the last Priorities and Risks Framework (PRF) document for Health in October 2010. The scene was set for many of these changes in the previous year when, in 2010, the Scottish Government published its Healthcare Quality Strategy for NHSScotland, as a development of the Better Health, Better Care document, intended to build on achievements over the last few years, such as improvements in waiting times, the approach to tackling Healthcare Associated Infection and improvements in patient safety in hospitals. Implementation of the strategy involves a range of actions by individuals, teams, NHS boards and the Scottish Government, and is expected to deliver measurable improvements in key indicators of healthcare quality.

2. There have also been significant changes in the public financial environment since the last PRF including the implications of the change to a majority administration at the Scottish Government after the Scottish Parliamentary Election of May 2011 and the subsequent decisions on spending allocations. The continuing effects of the wider economic downturn have also added to the specific pressures faced by NHS bodies and their partners in Scotland, particularly in the areas of financial management and capacity to deliver.

3. The substantively reviewed PRF of October 2008 (as revised) was intended to serve for an extended period, and largely it continues to do so. This 2011 edition should be seen as an update to those previous revisions rather than as a wholly new product.

Audit approach

4. The Priorities and Risks Framework for NHSScotland (NHSS) is intended to provide a common framework for the delivery of high-quality public sector audit across the health sector.

5. The PRF is one element of an audit approach which has been designed to meet the requirements of the Code of Audit Practice and International Standards on Auditing. These standards require auditors to understand their client's business and its environment. Our understanding of the business will be informed by the PRF, along with work undertaken to identify issues and risks which are unique to the local situation.

What is the role of the PRF?

6. The PRF is a national tool for auditors to use when planning the risk-based audits of public sector bodies in Scotland. It helps to ensure that audit work is properly focused and takes account of sector-specific national priorities and risks. The PRF identifies the key national initiatives and priorities facing clients in the coming year and the main risks to their achievement.

7. Although the PRF presents a national view, it will inform the planning of audits by combining this national view with the auditor's understanding of the key priorities and risks operating at

the local level. It is designed to focus the audit locally but is also likely to be used in the delivery of a cohesive, integrated and joined up audit across Scotland which addresses the priorities and risks of health bodies from a top down (national) and bottom up (local) perspective.

How is the PRF developed?

8. Sector specific PRFs are developed, generally annually, by multi-disciplinary groups from Audit Scotland and its stakeholder groups. This 2011 Health update has been produced by Audit Scotland staff from both its Audit Services and Performance Audit Groups, and in discussion with our partner firms.

How will auditors use the PRF?

9. The PRF forms an agenda for discussion with senior client officers to help auditors assess their client's arrangements to address the issues and risks identified in the PRF. Auditors may need to meet with many, if not most, of a client's management team to discuss their organisation's risks. These discussions will be supported by auditors' cumulative knowledge and experience of NHS bodies and a review of relevant evidence, including the reports of other scrutiny bodies. When combined with an assessment of local issues, audit activity can then be targeted to areas of greatest audit risk.

10. In reporting the results of the audit, auditors will be sensitive to the fact that, even though arrangements to address the issues in the PRF may be weak, the identified risks may or may not crystallise. The absence of, or deficiencies in, arrangements does not necessarily mean that identified risks are statements of fact. We also recognise that risk exists in all organisations which are committed to continuous improvement. The objective is to be 'risk aware', with sound processes of risk management, rather than 'risk averse'. Indeed, organisations which seek to avoid risk entirely are unlikely to achieve best value.

11. Auditors do not carry out detailed audit work on all the matters set out in the PRF, even if judged to be of high risk. Some areas are best addressed by other scrutiny bodies – such as Healthcare Improvement Scotland in relation to clinical governance – with other areas addressed through the monitoring of actions taken by management. Auditors meet with HIS to share intelligence and work plans.

How are the results of the PRF recorded and reported by auditors?

12. An appropriate recording mechanism for the results of the PRF is essential in ensuring local audit plans are supported by appropriate evidence. Auditors will prepare their risk assessment as part of their planning process, identifying and recording the current status of local developments in the key risk areas, the main risks to the priorities identified in the PRF, any audit work planned, and any developments planned by the client during the year. The risks identified and related audit work will be reported in annual audit plans submitted to the client. Local information on PRF issues from audit plans will be used to prepare an early position

statement for the Auditor General and to inform the further development of integrated overview reporting of the NHS.

Other matters

13. Audit Scotland has also developed a range of audit toolkits to cover the key Best Value (BV) principles. These BV toolkits are a key part of the practical application of the BV audit. They provide an evaluation framework which will help auditors to reach robust judgements on how public bodies are delivering BV. However, they cannot generate BV judgements on their own. They cover only part of the process. Judgements about BV also involve consideration of service standards and performance, outcomes and how effectively continuous improvement is being achieved.

14. There is considerable common ground between the key priority and risk areas set out in the PRF and the topics covered by the BV toolkits. The individual PRF sections therefore make reference to the related toolkits where it is felt that these could provide useful background in arriving at judgements on priorities and risks at NHS bodies. These are available, for information, to public bodies on Audit Scotland's website at www.audit-scotland.gov.uk

Service redesign and sustainability

Background

15. In December 2007, the Cabinet Secretary for Health and Wellbeing launched the Better Health, Better Care Action Plan, following the consultation document launched in August 2007. The stated aim of the plan is to "help people to sustain and improve their health, especially in disadvantaged communities, ensuring better, local and faster access to health care." The Scottish Government also published the Healthcare Quality Strategy in May 2010 which builds on Better Health, Better Care and aims to "deliver the highest quality healthcare services to people in Scotland". Its stated ambitions include making sure that the most appropriate treatments, interventions, support and services are provided at the right time to everyone who will benefit and getting rid of wasteful or harmful variation.

16. Actions within these plans are being taken forward by different workstreams. However, the Scottish Government has already taken a number of decisions which have a significant impact on health boards in Scotland in terms of their potential service redesign requirements.

- The Government has introduced Independent Scrutiny Panels, administered by the Scottish Health Council, which can be set up by the Cabinet Secretary to oversee major service redesign decisions taken by individual boards. Three separate Panels have already considered and assessed revised proposals for the reconfiguration of emergency care within Lanarkshire and Ayrshire, proposals for changes to NHS services in the Clyde area and proposals by NHS Dumfries and Galloway to redesign healthcare in that region. Information on the proceedings and findings of these panels can be accessed on the Independent Scrutiny Panels website.
- Waiting times targets have also been a focus for the Government, with the introduction of the 18 week waiting time target from referral to treatment, which all boards must comply with.
- The Government has changed the funding mechanisms for large capital projects within the public sector, replacing PFI/PPP arrangements with the Scottish Futures Trust.
- The Patient Rights (Scotland) Bill was passed by the Scottish Parliament on 24 February 2011, and the Patient Rights (Scotland) Act 2011 received Royal Assent on 31 March 2011. The Act makes provision for the rights of patients when receiving healthcare, and introduces, amongst other measures:
  - a Charter of Patients' Rights and Responsibilities
  - Health Care Principles to be upheld by NHS bodies
  - the concept of Treatment Time Guarantees.

17. The impact of these developments will need to be assessed by health boards, and reconciled with their long-term strategies. Service redesign may be required to manage the impact and

enable health boards to meet their objectives. Other drivers for service redesign are also becoming more evident. The need to drive efficiencies from current operations is a focus for the majority of health boards, particularly given the efficiency savings targets and the need to meet these on a sustainable basis. Health boards need to ensure that their strategies are achievable within the financial resources available to them and need to recognise that there will now be even tighter financial settlements in 2011/12 and future years. Budget pressures on Local Authorities and on the voluntary sector are likely to have a consequential impact on NHS resources.

18. Current population demographic forecasts reinforce predictions of an ageing population over time. Current projections suggest that by 2035 the Scottish population will have aged markedly with the number of people in the 60 plus age bracket increasing by 45 per cent from 1.207 million in 2010 to 1.755 million, with a significant increase (82 per cent) in the over 75 age groups.[1] This forecast presents an additional challenge to health boards to ensure that their long-term service provision will meet the needs of the whole population.

19. The NHS faces a number of key challenges in redesigning its services to ensure they are sustainable in the short, medium and long-term:

- service redesign can only be fully achieved by bridging the gap between primary and acute care and working in partnership with others. This requires integrated service planning at a local and national level, which is based on NHS Boards' formal duty to participate in regional planning groups and cross-boundary managed clinical networks (MCNs). With even tighter financial settlements expected in future years, all partnership bodies will need to work closely together to ensure that the shift in the balance of care is achieved without impacting upon affordability
- workforce plans and financial plans need to be fully aligned with clinical strategy, and plans to implement the Quality Strategy, to ensure that it can be delivered and sustained
- affordability and the ability to demonstrate best value and benefits realisation need to be considered
- implementation of robust systems to obtain information on current and future service provision will be needed, including the consideration of patient needs and expectations
- significant service redesign activities can be subject to independent scrutiny, and boards need to incorporate the requirements and possible implications of this process into their plans
- ensuring redesigned services are safe and effective and improve the quality of care and treatment of patients
- ensuring that there is sufficient management capacity to deliver change successfully.

[1] Projected Population of Scotland (2010 Based) - , General Register Office for Scotland, October 2011

Links to other work

20. Audit Scotland's Overview of the NHS in Scotland's Performance 2008/09 (December 2009) examined a range of issues relevant to the consideration of service redesign and sustainability, and its Financial Overview of the NHS in Scotland 2009/10 (December 2010) discussed the financial pressures within which service changes will require to be framed. Our report on Scotland's Public Finances: addressing the challenges, which was published in August 2011, stated that the scale of budget cuts brings immediate challenges to reduce expenditure, but also to ensure long term sustainable public services.

21. In August 2010 Audit Scotland published its report on Emergency Departments which highlighted variations in provision and called for a Scotland wide approach to emergency care.

22. In October 2011, Audit Scotland published its report on Telehealth in Scotland. The report highlighted the potential for telehealth to help deliver urgent clinical services more efficiently and effectively, and that boards should be considering it when introducing or redesigning services, in order to achieve cost and clinical benefits.

Key risks

23. These include:

Vision and consultation

- Without service redesign the board cannot continue to meet the demands of its patient population, including better, local and faster access to healthcare, and an improvement in the patient's experience, as outlined in Better Health, Better Care and the Healthcare Quality Strategy. If internal and external stakeholders (such as Community Health Partnerships (CHPs), operating divisions, patients, local authorities, regional planning groups, Scottish Government Health and Social Care Directorates (SGHSCD) and Scottish Ministers) are not fully involved in service redesign, there may be a lack of financial and operational commitment. In the current economic climate it is important that stakeholders are working together when redesigning services that shift the balance of care and its associated costs. The board should be able to show that:
  - it has a vision of where the organisation will be in the next 3 – 5 years and beyond, informed by an understanding of internal and external stakeholders' needs and national priorities and policies
  - it is engaging with stakeholders to gain their support and obtain their involvement and commitment to service redesign
  - plans for service redesign are sufficiently robust and flexible to deal with foreseeable implications arising from independent scrutiny reviews.

Integrated planning

- The lack of an integrated planning process results in poor links between service delivery, financial constraints and the requirement to meet national priorities and targets, restricting the range of possible redesign options. The board should have an integrated approach to

planning, taking account of local, regional and national priorities and ensuring that all published plans are financially and operationally achievable.

- Business plans may not be aligned with workforce plans, leading to the board having a lack of staff and skills required to meet their targets and future plans. Boards should be able to demonstrate clear alignment in this area.
- Financial plans do not fully consider future service delivery or appropriately consider financial pressures. Financial plans (short and medium-term) should fully consider longer-term service reconfiguration and redesign.

Performance management

- There is a lack of robust management information, preventing the board from accurately determining current service delivery costs, activity levels and performance, and impacting on its ability to plan future service delivery. The board should have completed a baseline assessment to establish these measures and identify if there are any gaps in service or capacity. Plans should be based on robust current and estimated future service and activity levels, properly costed and with clear links between operational objectives and financial and workforce requirements.
- Redesigned services do not demonstrate best value or provide efficiency savings, or are not safe and effective. Arrangements should be in place to:
  - identify variations in practice and share good practice in a bid to achieve continuous improvement
  - provide assurances that redesigned services are safe and are improving the quality of care for patients
  - prepare benefits realisation plans and measure achievement against these e.g. for pay modernisation initiatives to demonstrate actual benefits achieved.

Project management

- Poor programme and project management results in late or inefficient and ineffective project delivery for key redesign projects. The board should have assessed its management capacity to deliver its vision and programmes of service improvement, including executive leadership, risk and change management, programme and project management requirements, and workforce requirements. Ongoing operational requirements should continue to be met, and levels of quality and safety sustained.
- NHS Boards do not follow relevant processes to ensure that their funding requirements for service redesign are met through the most appropriate mechanism. These processes should include option appraisal and the implementation of a mechanism for reviewing the effectiveness of these processes.

Re-allocation of resources

- Inadequate procedures exist to identify and dispose of redundant assets and manage staff redeployment resulting from continued service redesign. The board should operate an effective asset management strategy and workforce plans should take account of the consequences of service redesign.

Effective partnership working

Background

24. NHS boards must be able to demonstrate that they are delivering effective services for patients and their carers and achieving value for money. Partnership working in the NHS covers a number of areas including partnerships with staff groups, local authorities, the voluntary sector, private healthcare providers and regional planning with other NHS boards. Working in partnership will help the health service to meet its strategic objectives, address local needs and meet future challenges such as reducing budgets and increasing elderly population.

25. The NHS Reform (Scotland) Act 2004 required NHS boards to establish one or more Community Health Partnerships (CHPs) in their local area to bridge the gap between primary and secondary healthcare, and also between health and social care. CHPs were expected to coordinate the planning and provision of a wide range of primary and community health services in their area. This includes GP services; general dental services; all community-related health services; mental health services; and community-based integrated teams, such as rapid response and hospital at home services. NHS boards were also given flexibility to devolve any other function or service to the CHP. NHS boards and partners have established different CHP arrangements across Scotland, which means there are significant differences in the size, role, function and governance arrangements of CHPs. In 2009/10 NHS boards and councils spent a total of £13 billion on health and social care. Audit Scotland's review of Community Health Partnerships (June 2011), identified that CHPs directly manage only 26 per cent of total spending and there is variation in the services for which they are responsible.

26. In Better Health, Better Care (2007), the Cabinet Secretary for Health and Wellbeing emphasised the need to work in a coordinated way across Government to develop patient care, and community and public services. The health service must work together with its partners to place the patient at the heart of everything it does and integrate care to realise efficiencies and ensure it achieves the highest standards of quality and safety. The Scottish Government published the NHS Quality Strategy in May 2010 which develops the issues set out in Better Health, Better Care and emphasises the need to 'work together across NHSScotland, with partners in the Public Sector and Third Sector to improve the quality of care.

27. There is an expectation that all public sector bodies, including the NHS, should be able to demonstrate how their activities are aligned with the government's over-arching purpose through the National Performance Framework. Councils have a statutory duty to coordinate community planning in their areas and report annually on overall progress in improving services and outcomes for local people. NHS boards and a number of other public sector bodies have a statutory duty to participate in community planning and provide information to

the council on their contribution to enable the council to prepare its annual Single Outcome Agreement (SOA) report. SOAs commit partners to delivering outcomes that they cannot achieve alone and increases the focus on effective partnership working. This increases the flexibility available to these bodies, but it also increases the need to ensure that there are very clear funding agreements or budget alignments in place within partnerships. In 2008, Scottish ministers gave CPPs the lead role in tackling health inequalities. An important part of community planning is to engage with local communities so they can contribute to how services are planned and to support them to contribute to their own well-being. This is also an important feature of health policy in Scotland.

28. A new Scottish Health Council Participation Standard was published in August 2010. This requires NHS boards to routinely communicate with and involve the people and communities they serve to inform them about their plans and performance.

Links to other work

29. In June 2011, Audit Scotland published a review of Community Health Partnerships across Scotland. This report showed that CHPs were set up in 2004 with a challenging agenda. They were expected to provide certain community-based health services, bridge the gap between primary and secondary healthcare services, and contribute to improving joint working between health and social care. However, these responsibilities did not come with the necessary authority to implement the significant changes required. The audit highlights that irrespective of structure, partnership working depends on good local relationships, a shared commitment and clarity of purpose.

30. The audit of CHPs also highlighted that approaches to partnership working have been incremental and there is now a cluttered partnership landscape and a risk of duplication and a lack of clarity of the role of the CHP and other partnerships in place in a local area. The report sets out some key principles that all partners should follow to improve joint working and highlights that differences in organisational cultures, planning and performance and financial management are barriers that need to be overcome. CHPs' governance and accountability arrangements are complex and not always clear, particularly for integrated CHPs, and a more systematic, joined-up approach to planning and resourcing is required to ensure that health and social care resources are used efficiently.

31. Audit Scotland's national cross-cutting report Scotland's Public Finances: addressing the challenges highlighted potential for greater joint working between public bodies and with the private and voluntary sectors to improve services through an increased focus on the user.

32. As part of its programme of work on the audit of Best Value, Audit Scotland developed a toolkit on partnership working. This has been applied in a number of NHS bodies and covered a number of key issues including governance, the involvement of communities in the partnership process, performance measures and delivering outcomes.

33. The Scottish Government is developing an integrated resource framework which aims to provide better information on how health and social care money is spent. This aims to help NHS board and councils to develop a better understanding of how they are currently using

their resources to support better joint planning and investment decisions. This information is being used to support the local developments based on the introduction of the Change Fund. A Change Fund to help joint working between NHS boards and councils was announced as part of the 2011/12 Scottish budget. In 2011/12, £70 million has been made available to NHS boards and councils to implement local plans for making better use of their combined resources for older people's services. The Change Fund is expected to continue for up to four years, providing short-term funding to facilitate shifts in the balance of care and influence decisions on overall health and social care spend on older people's care.

Key risks

34. These include:

Commitment and leadership

- Lack of leader visibility in promoting partnership activities
- The NHS board is not committed to local partnership working. The NHS board should be able to demonstrate commitment to partnership working and joint service delivery. It should also be able to provide examples where joined-up service delivery has made a difference at a local level.
- CHPs/CHCPs are not seen as a key driver to improve local health services, support service redesign and facilitate community based care. The NHS board should be able to demonstrate the outcomes that the CHP/CHCP has achieved for patients.

Responsibility and accountability

Partner organisations are unclear about their areas of responsibility and delegated authority. The NHS board should be able to show that joint governance arrangements are in place with clearly defined lines of communication, accountability and delegated authority between partner organisations.

Planning

- Partner organisations lack clarity as to how community planning arrangements, and CHPs/CHCPs should interlink thereby leading to inefficiency and possible duplication of effort. Arrangements should be in place to ensure that partners have agreed joint service delivery objectives and a development plan, or equivalent, has been put in place for their implementation.
- Strategic priorities may not be fully integrated within NHS or partners' corporate and service plans. Services may therefore not be working towards agreed strategic priorities. Plans should have clear links to the board's Local Delivery Plan, Council Service Plans, Community Plan and the plans of other partner organisations. The contribution of the NHS to SOAs must also be clear. Plans should not just reflect national priorities but also address local needs.

Resources

- Resources identified for joint working are insufficient to deliver the services and joint funding arrangements have not been fully endorsed by partners. The NHS board should be able to demonstrate that:
  - joint planning is supported by a financial strategy that includes detailed and realistic resources to achieve jointly agreed objectives and priorities
  - pooled or aligned budgets have been agreed among partner members as well as their respective contributions
  - base budgets are reviewed on an annual basis with regular monitoring of expenditure during the year by partners
  - resource transfer is accounted for and used for its intended purpose
  - there are agreed protocols for the virement of expenditure between accounts.

Sharing information

- Arrangements are not in place to share information across organisational or professional boundaries. The board should have a communication strategy (or protocol) in place with other partner organisations for sharing information and for agreeing any changes in service provision.

Performance management

- A joint performance management framework is not in place resulting in poor and untimely decision-making. Partner organisations are unable, therefore, to demonstrate that they have been effective in shifting the balance of care from acute to community settings based at a local level and in improving local health services. The NHS board should have procedures in place for ensuring that:
  - key performance measures have been identified, and defined, for areas of joint working and these are regularly monitored and reviewed
  - performance management reporting lines and timescales are clear
  - performance monitoring arrangements are sophisticated enough to provide evidence of improved service delivery as a result of partnership working, including through SOAs, and can align to the National Performance Framework.

Scrutiny and governance

Background

35. The core principles of good governance are described in the *Good Governance Standard for Public Services* issued by the Independent Commission on Good Governance in Public Services. The standard describes the function of governance as 'ensuring that an organisation fulfils its overall purpose, achieves its intended outcomes for citizens and service users and operates in an effective, efficient and ethical manner'. Robust governance arrangements in an organisation should lead to good management, good performance, good stewardship of public money, good public engagement and, ultimately, good outcomes.

36. A strong governance framework is even more important in a culture of continuous improvement and in an environment of rapid and major change. Boards need regular assurances from managers on these procedures in forming their own views on effectiveness. Appropriate disclosure on the effectiveness of control mechanisms is also made in the annual Statement on Internal Control.

37. The NHS must work in partnership with local authorities and other partners to deliver better care for patients. CHPs and other partnerships are responsible for delivering an increasing number of services, and effective governance arrangements are important if partnerships are to work well.

38. *Better Health, Better Care* also introduced independent scrutiny of proposals for major service redesign by boards and included consideration of direct elections to NHS boards as a means of increasing accountability.

39. The Health Board (Membership and Elections) (Scotland) Act 2009 is changing the constitution of health boards by introducing a system whereby a proportion of the board membership will be elected members. The Act provides for the elections to be introduced on a pilot basis and pilots are underway in several Board areas. Scottish ministers are required to publish an evaluation report on the pilot scheme elections which will run for a minimum of two years, and following that report, the Act provides for ministers to roll out the scheme by order.

40. On 1 April 2011, Healthcare Improvement Scotland (HIS) began operating. It has a key role in setting standards for care and treatment and then inspecting boards' performance against them. HIS is now responsible for the regulation of independent healthcare, a role which previously belonged to the Care Commission. As such HIS will register and inspect services against the national care standards. It can also take enforcement action against an independent healthcare provider and has the power to cancel a service provider's registration.

Governance

41. The key components of governance within which NHS boards are required to operate are financial governance, staff governance, clinical governance and information governance. In

2011/12 NHSScotland intends to develop a single transparent and effective framework for governance to support its Quality ambitions.

42. **Financial governance**. This places a responsibility upon the board and, principally, the accountable officer, to maintain a sound system of internal control, comply with all applicable laws and regulations and maintain its financial position so that it can meet its obligations as and when they fall due. High standards of financial stewardship are achieved through effective financial planning and strategy, financial control, and through maximising value for money. Financial governance issues are also addressed in the chapter on Financial management and affordability.

43. **Staff governance**. This refers to a system of corporate accountability for the fair and effective management of all staff. Boards have a statutory duty in relation to staff governance as outlined in the Staff Governance Standard. This sets out the minimum level of performance expected. NHS boards' staff governance committees are responsible for creating the appropriate culture for people management and monitoring performance against the standards. The standard applies to all NHS staff including those involved in joint futures and community health partnerships.

44. The Staff Governance Standard requires staff survey results, the self-assessment audit tool (SAAT), the Staff Governance Action Plan and progress reports to be submitted to the Scottish Government by 31 March each year to ensure that progress on staff governance implementation can be monitored and used to inform the annual review process.

45. **Clinical governance**. In the white paper *Designed to Care*, clinical governance was defined as 'corporate accountability for clinical performance'. It is the system for making sure that healthcare is safe and effective and that patients and the public are involved. NHS QIS previously carried out reviews of all boards, however, this role has now been taken over by HIS. Clinical Governance is also covered in the chapter on Patient Safety and Clinical Governance.

46. **Information governance**. Information Governance provides the necessary safeguards for the disclosure, and appropriate use of, patient and personal information. Health boards should be aware of the extent and limitations of their powers and act accordingly. Staff must be trained in the correct procedure for handling confidential patient information and should also be provided with procedures for obtaining guidance where they are unsure whether they should disclose information. Information Governance risks are also addressed in the chapter on Capacity to deliver. In November 2011 NHSScotland issued CEL 26 (2011) Information Assurance Strategy, which sets out the strategic direction for further developing the service's Information Assurance capability and effectively embedding an IA culture across NHSScotland.

Scrutiny

47. The work of health boards is subject to a range of internal and external scrutiny arrangements:

- **Internal scrutiny**. Internal scrutiny of health boards is provided by non-executives, internal performance monitoring systems and the work of internal audit. One of the main

aspects of the role of non-executive members of boards is to challenge and to hold executives to account. They must be provided with the necessary information to support effective challenge.

- **External scrutiny**. External scrutiny includes external audit, inspections by HIS, and annual reviews by the Cabinet Secretary. In addition, *Better Health, Better Care* introduced the policy of Independent Scrutiny Panels to assess whether all options have been considered and the views of the public taken into consideration when boards are planning major service redesign.

Links to other work

48. As part of its programme of work on the audit of Best Value, Audit Scotland has developed a range of Best Value toolkits. These include a toolkit on people management, which has been applied to a number of NHS bodies based on local risks and priorities. A toolkit has also been prepared on governance and accountability and Boards are able to use them to self –assess their own performance and identify areas for improvement.

49. Audit Scotland produced its report on The role of boards in September 2010, covering arrangements across the public sector. The report noted that boards' approaches to governance were not always consistent and recommended that public bodies should ensure that their boards focus their scrutiny on organisational performance, financial management and risk management.

50. In June 2011, Audit Scotland published its report on the *Review of Community Health Partnerships*. One of the key messages highlighted by the report was that governance and accountability arrangements for CHPs are not always clear and need to improve. More detailed consideration of these issues is included within the chapter on effective partnership working.

Key risks

51. These include:

Committee structures and remits

- The governance framework implemented locally does not contribute to an effective, efficient and economic local health service. The board should be able to demonstrate that it has an effective committee structure and that committee role, membership and terms of reference comply with current guidance (eg the Audit Committee Handbook).
- Committee agendas are so lengthy that insufficient time is allowed for adequate discussion of each item. This could lead to important matters being dealt with without adequate discussion and debate. Boards should be able to demonstrate sound agenda and time management arrangements for committees affording key issues the appropriate discussion time.

Scrutiny

- Information submitted to the board and its committees is insufficient for members to assess the impact of decisions on resources and performance. Reports submitted to the board and its committees should contain sufficient detail to allow members to discharge their governance duties.
- Non-executive board members lack the capacity to fully or effectively carry out their governance role and are reactive to strategy and direction provided by executives. They are, therefore, unable to challenge effectively and hold management to account. The board should be able to demonstrate that it is providing training and seminars for non-executives on current and topical issues to ensure that they can effectively engage with executives and hold them to account, and that new non-executive directors receive induction training covering their scrutiny role.
- The board fails to implement the agreed actions arising from the annual review process which may result in direct intervention by the Scottish Government. The board should provide evidence that appropriate governance measures are in place to progress the action plan agreed with the Scottish Government.
- The board is unable to implement the proposals of the Independent Scrutiny Panel because of financial and service delivery constraints. The board should be able to show that financial plans incorporate contingency measures that take into account possible revisions of their services arising from the findings of any Independent Scrutiny Panel.
- The board has inadequate arrangements in place to comply with the Staff Governance Standard and ensure that robust plans are submitted on time to the Scottish Government each year.

Consultation

- Public involvement and stakeholder and staff consultation are not integrated within the board's policy and decision-making processes. The board should be able to demonstrate that it has arrangements for consulting with staff, patients, the public and other key stakeholders and that the board's plans and actions are informed by an understanding of their needs. Boards are also required to meet the new Participation Standard.

Risk management

- Failure to implement a robust risk management framework results in key business risks, and their potential impact, not being properly identified or being addressed in the board's business and controls processes and potentially impacting upon the achievement of its objectives. The board should be able to show that:
  - it has a systematic approach to identifying the key risks facing the organisation, with risk registers properly maintained
  - it takes steps to manage these risks, with the content of risk registers feeding into the preparation of service plans and the development of appropriate controls

  - effective clinical governance and risk management arrangements are in place to support the delivery of safe, effective, patient-focused care and services.
- Boards may not be as focused on risk management as they should be. While it is appropriate for risk management to be delegated to another committee (usually the audit committee) it is important that the whole board takes ownership of the risk oversight function. All members should be fully aware of the major risks and be satisfied that the right preventative action is being taken

Controls framework

- Failure to implement a robust control framework results in a breakdown in core business system processes and controls and, ultimately a failure to maintain service delivery. The board should be able to provide evidence that:
  - sound systems of performance management – covering financial and workforce issues, as well as service delivery – are in place to support good governance and to monitor progress against the targets set by SGHSCD
  - it carries out a review of the effectiveness of the systems of internal control which is used to support the Statement on Internal Control contained within the annual accounts
  - it has developed a framework to demonstrate how it is addressing and implementing the key themes of best value. The board will require to disclose its arrangements for best value within the Statement of Internal Control included within the 2011/12 financial statements
  - it has well documented and published anti-fraud measures and is committed to the National Fraud Initiative in Scotland.
  - it has put in place clear plans to meet the requirements identified from any HIS peer review and these will be regularly monitored to ensure that clear improvements are made prior to the next annual review involving the Cabinet Secretary, where applicable.

Partnership working

- Effective governance structures and accountability arrangements are not in place for all areas of partnership working including CHPs and regional planning groups. The board should be able to demonstrate that it has considered the key messages in the Audit Scotland report on the *Review of Community Health Partnerships (June 2011)* and developed an action plan of improvements appropriate to local circumstances. A joint risk register and arrangements for monitoring this should also be in place. Partnership working issues are further addressed in the chapter on Effective Partnership Working.

Major projects

- Effective governance structures are not in place to support major areas of service re-design resulting in delays, financial overruns and failure to achieve service objectives. The board should be able to demonstrate that specific governance arrangements have

been established to support major projects including the monitoring and reporting of progress against plan/budget.

Information governance

- Staff do not fully understand their duty to keep data confidential. An information security policy that aligns with the national policy and Caldicott guidance should be in place. Codes of practice that govern and control data exchange with other organisations should also be agreed. The board should also be able to demonstrate that it has measures in place to monitor staff compliance with published security and data handling procedures.
- The board does not fully comply with all information assurance legislation (eg the Data Protection Act or the Freedom of Information Scotland Act) and cannot provide assurance that partner organisations apply appropriate security safeguards when handling NHSS data. The board should be able to demonstrate that information assurance measures are in place which support the annual assessment of information risk management.
- The board does not have adequate procedures in place to minimise the risk of data loss. The board should be able to demonstrate that it has responded appropriately to the Scottish Government's Review of Data Handling (June 2008).

Patient safety and clinical governance

Background

52. Patient safety is a significant concern to patients, the public and the NHS. Research studies have found that one in ten patients in Scotland may experience an adverse event in hospital and half of these have been judged to be avoidable. *Better Health, Better Care* states that one of the priorities for the Scottish Government is to improve patient safety, including a movement to 'a quality improvement and safety culture in our hospitals underpinned by the capability and capacity required to sustain this culture over the long term'. In May 2010, the Scottish Government published its *Healthcare quality strategy for NHSScotland*, which identifies actions for improvements in priority areas based on three healthcare *Quality ambitions*, one of which is 'There will be no avoidable injury or harm to people from the healthcare they receive, and an appropriate, clean and safe environment will be provided for the delivery of healthcare services at all times.'

53. Currently, in relation to patient safety, the HEAT targets are that by March 2013 NHS boards should have: reduced staphylococcus aureus bacteraemia (including MRSA) cases to 0.26 cases or less per 1,000 acute occupied bed days; and reduced the rate of Clostridium difficile infections in patients aged 65 and over to 0.39 cases or less per 1,000 total occupied bed days. Twelve quality outcome indicators have been developed to support the Healthcare quality strategy and these are at different stages of development:
    - Healthcare experience
    - Staff engagement and potential
    - Healthcare Associated Infection (HAI)
    - Emergency admission rate/bed days
    - Adverse events
    - Hospital Standardised Mortality Ratio
    - Under 75 mortality rate
    - Patient/User Reported Outcome Measures (PROMs)
    - Self-assessed general health
    - Percentage of time in the last 6 months of life spent at home or in a community setting
    - Early years indicator
    - Resource use indicator

54. Healthcare Improvement Scotland (previously NHS Quality Improvement Scotland) has lead responsibility for reviewing boards' performance in relation to quality and patient safety, and

for working with boards to improve patient safety. Audit Scotland and NHS QIS agreed an operational protocol that aims to:

- help ensure the effectiveness of Audit Scotland and NHS QIS in fulfilling their responsibilities
- minimise the burden of scrutiny on NHS bodies
- help provide consistent feedback to NHS bodies.

55. Auditors should meet with Healthcare Improvement Scotland (HIS) as part of their risk assessment so they know what work HIS has already done in each board and what work is planned in the audit year. Auditors are not expected to carry out any specific audits on patient safety in their boards – they should use the work of HIS as far as possible, and should also share their intelligence with HIS to inform their work. Auditors' work should be limited to satisfying themselves that the board is taking action to address any concerns identified by HIS / NHS QIS and to continuously improve.

56. Patient safety is at the heart of clinical governance and risk management. HIS published a draft Healthcare Quality Standard in July 2011 which will replace previous national standards for clinical governance and risk management. The draft standard was issued for consultation and HIS has not yet published the final standard. The previous clinical governance and risk management standards were published in 2005 and NHS QIS carried out a second round of review visits between May 2009 and May 2010. It published local reports for individual boards and a national overview.

57. HIS is implementing a new healthcare scrutiny model that aims to be risk-based and proportionate, with a focus on boards' ongoing self-evaluation and quality improvement. The draft Healthcare Quality Standard states *"Rather than waiting for us to review performance, we expect healthcare organisations to demonstrate that they are actively implementing the clinical governance and risk management principles set out earlier* [in the Healthcare Quality Standard]." The new approach includes using a Quality Risk Profile for each board to help HIS prioritise boards for review. The profile is being developed to bring together a range of information about the board, including data on outcomes, findings from external reviews and intelligence from HIS and other bodies including external auditors and Audit Scotland's national performance audit reports. The new scrutiny approach is expected to be tested in late 2011 and 2012 and the timescale for reviews is not yet known.

58. The Healthcare Environment Inspectorate (part of HIS) will be carrying out inspections of services for older people in acute hospitals from November 2011. These reviews were requested by the Cabinet Secretary for Health, Wellbeing and Cities Strategy in June 2011. The reviews are based on the standards for care of older people which the Clinical Standards Board for Scotland (the predecessor to NHS QIS) published in 2002.

Scottish Patient Safety Programme

59. The SGHSCD set up the Scottish Patient Safety Alliance (SPSA) in 2007, bringing together the Scottish Government, health boards and special boards, professional bodies, patient

representatives and other groups. As its first programme of work, the SPSA launched the Scottish Patient Safety Programme (SPSP) in January 2008. The SPSA was disbanded in 2010 and the Quality Alliance Board was set up to support and drive the implementation of the Healthcare Quality Strategy. This SPSP programme is continuing, coordinated by HIS, and its aims are to systematically improve the safety and reliability of hospital care throughout Scotland.

60. The programme is driving improvements across the five workstreams of Leadership, Critical Care (care provided in intensive care units), General Ward, Medicines Management and Perioperative (before, during and after surgery) and aims to:

- achieve 15 per cent reduction in mortality
- achieve 30 per cent reduction in adverse events
- reduce healthcare associated infections (HAIs)
- reduce adverse surgical incidents
- reduce adverse drug events
- improve critical care outcomes
- use data for improvement
- develop and build a quality improvement and patient safety culture in our hospitals.

61. NHS boards and the Golden Jubilee National Hospital (GJNH) should have an executive lead and SPSP manager, and should have set up multidisciplinary teams to drive local improvements across the five workstreams. Boards are expected to be working towards the overall aims and goals for the SPSP. They may have agreed a local action plan (which may be a stand-alone plan or integrated with other local plans) and have systems to measure improvements. Boards are not required to submit any plans to the SGHSCD or HIS.

62. Boards submit information on progress against national measures, with supporting narrative, to the Institute for Healthcare Improvement (HIS's technical partner) on a monthly basis. This information is intended to be used by boards themselves as part of continuous improvement and is not reported publicly. The key focus of the SPSP is developing a safety culture in boards and promoting self-assessment and continuous improvement, rather than implementing national performance management arrangements.

63. The SPSP has been implemented initially in acute hospitals in all territorial boards and the GJNH, but has now been further expanded to encompass other service areas, including Paediatrics and Primary Care services. The Scottish Patient Safety Paediatric Programme (SPSPP) was launched in June 2010, to support paediatric staff in improving the quality and safety of paediatric healthcare. The key objective of the SPSPP is to reduce adverse events by 30 per cent by June 2013, and the infrastructure to support this was to be established in NHS boards by end December 2010. The Safety Improvement in Primary Care Programme also started in November 2009. A workplan for this programme has been developed and it will be widely rolled out from March 2013. Preparatory work will take place in 2011/2012, including

gathering information on what is currently happening in relation to patient safety in primary care in Scotland.

Healthcare Associated Infection

64. The Healthcare Environment Inspectorate (HEI) was set up in April 2009 as a new inspectorate based within NHS QIS (now HIS). Its remit is to reduce the risk of HAIs in acute hospitals through assessment, inspection and reporting of boards' performance against HAI standards. HEI will carry out announced and unannounced inspections in each acute NHS hospital in Scotland at least once every three years, and will carry out at least one inspection visit per annum for every relevant NHS board. The visits are a mix of announced and unannounced inspections. NHS boards are expected to produce improvement plans following local inspections.

65. In January 2009, the Scottish Government issued a Chief Executive Letter, Zero tolerance to non hand hygiene compliance, which states that NHS board chief executives are required to ensure that hand hygiene policies are consistently applied by all healthcare workers and that sufficient resources are made available to allow staff to fully comply with local hand hygiene policies.

66. NHS QIS published updated HAI standards in March 2008. A Health Department Letter issued in 2005 stated that all boards should have an infection control manager who is a board member or directly accountable to a board member. The infection control manager should have overall responsibility for management processes and risk assessment relating to all aspects of infection control. The HDL states that the scale of the role will mean that this should be a full-time, or close to full time, role in most boards. The infection control manager is expected to report directly to the chief executive and the board, and be an integral member of the board's infection control, clinical governance and risk management committees.

67. Inappropriate use of antibiotics is linked with increased HAI resistance to antibiotics. Guidelines on Antimicrobial Prescribing Policy and Practice in Scotland were issued to boards in 2005. Further guidance was published in February 2008 in the Scottish Management of Antimicrobial Resistance Action Plan (ScotMarap). All boards are expected to have an antimicrobial management team that covers primary and acute care. The Scottish Government issued antibiotic prescribing indicators in support of the HEAT target for C. difficile infection in May 2011.

Use of controlled drugs

68. New UK regulations on the management of controlled drugs came into place in Scotland in March 2007, following the Shipman review. The three key elements of the regulations are: the appointment of accountable officers; co-operation between health bodies and other organisations in relation to controlled drugs; and new powers of entry and inspection. The accountable officer is responsible for a range of measures relating to monitoring the safe use and management of controlled drugs and taking appropriate action where necessary.

Links to other work

69. HIS has responsibility for monitoring boards' compliance with quality standards for clinical governance and risk management and for coordinating the SPSP.

70. HEI is responsible for carrying out HAI reviews of acute hospitals and producing reports. HEI will make announced and unannounced inspections in every acute hospital at least once every three years. It will also carry out an annual inspection in each NHS board.

71. Audit Scotland completed the following relevant review in 2011:

- *Community Health Partnerships*, includes comment on the impact of CHPs on people's health and quality of life. This report was published in June 2011 and includes recommendations for boards.

Key risks

72. Auditors should review HIS reports and, if necessary, meet with HIS to discuss these key risks in the board. The key risks include:

Leadership and culture

- The board and its CHP/CHCPs do not actively demonstrate commitment to improving patient safety at the highest levels. They do not take action to actively promote a patient safety culture. The board should be able to demonstrate that:
  - patient safety is championed at board level and CHP/CHCP level
  - there is clear accountability for patient safety at board and CHP/CHCP level
  - it actively promotes a focus on patient safety throughout the organisation
  - patient safety is embedded in its policies and procedures
  - it actively promotes a culture of learning and continuous improvement in relation to patient safety throughout the organisation.

Integration of patient safety into governance arrangements

- The board and its CHP/CHCPs have not integrated all components of patient safety into its overarching clinical governance and risk management arrangements, meaning that committees do not have an overview across all relevant work and are not able to exercise their responsibilities fully. The board should be able to demonstrate that:
  - patient safety is a key consideration for the board, the clinical governance committee and the risk management committee, and for appropriate committees at CHP/CHCP level
  - appropriate committees receive regular updates on the SPSP that allow them to monitor progress
  - the infection control manager reports to the appropriate committees
  - it has an antimicrobial management team that covers primary and acute care and which links into appropriate committees, directly or through the HAI structures

- the accountable officer for controlled drugs links to the appropriate committees.

Integrated planning

- Patient safety is not fully considered when planning, redesigning and providing services. The board should be able to demonstrate that:
  - patient safety, including ensuring best practice in preventing HAI and complying with hand hygiene policies, is considered and embedded in its Local Delivery Plan and in other strategies
  - the financial plans and budgets for new developments and changes to services build in the cost of patient safety requirements
  - decisions on the location of services and specialties take full account of patient safety issues.

Continuous improvement

- The board and its CHP/CHCPs do not make use of their own monitoring information, the findings from external reviews and comparative national data, and do not take action to continually improve patient safety. The board should be able to show evidence that:
  - it has a clear process for considering internal and external reports and standards that relate to patient safety, such as reports and standards issued by HIS, HEI and Health Protection Scotland, developing action plans and monitoring progress against them
  - the board, clinical governance committee and risk management committee are provided with information to provide assurance that the board is acting on these reports and to allow them to fulfil their challenge role
  - board committees consider progress against the SPSP on a regular basis.

Communication and support

- The board and its CHP/CHCPs have not communicated the importance of patient safety and the responsibilities of staff, patients and the public, and have not put in place training and support to help staff, patients and the public fulfil their responsibilities. The board should be able to demonstrate that:
  - it has taken action to communicate to staff, patients and the public what they should be doing to reduce the risks to patient safety
  - it has put in place the training and infrastructure necessary to allow people to fulfil their responsibilities, such as having appropriate arrangements for hand-washing
  - it is committed to using incident and near-miss reports as an opportunity to make improvements and has taken action to encourage staff to report incidents and near-misses as part of a quality improvement culture.

Financial management and affordability

Background

73. Scotland's economy has been adversely affected by the recent economic downturn while pressure on the Scottish public sector has increased significantly because of the impact of the UK spending review in October 2010.

74. Between 2005/06 and 2010/11 the health budget rose in line with the overall Scottish budget, with both increasing by 28% in cash terms. In the latest budget, the health component was partly protected because of the Scottish Government's decision to pass on the Barnett consequentials resulting from increases in UK health spending. As a result, the 2011/12 health budget increased by 2% in cash terms overall, compared to a 3% reduction in total Scottish budget. In real terms, this equates to a reduction of 1% in the health budget and a 6% reduction in the total Scottish budget. However, within the health sector, Special health boards will experience an average 3% reduction in their revenue budget allocations in real terms.

75. The position going forward is one of overall budget reductions. In September 2011 the Scottish Government's Finance Secretary stated:

    "Between 2010/11 and 2014/15, Scotland faces a real terms cut of 12.3 per cent - £3.7 billion – including a real terms cut of 36.7 per cent to our capital budget. Against this stark backdrop, we will steer a distinct course and make the very best use of the constrained resources available to us."

    The Scottish Government has estimated that it may take until 2024/25 before spending levels return to 2010/11 levels.

76. It will be very challenging to maintain current levels of public services and meet new demands when resources are under such pressures. These pressures relate, among other things, to increasing demand for services largely due to an ageing population) increasing costs of delivery (particularly prescribing costs), the need to identify and deliver significant recurring cost savings, the financial strain in delivering nationally determined service targets and rising inflation.

77. In this context, health bodies will be required to deliver significant efficiencies. The efficiency savings target for the Scottish public sector, including NHSScotland was increased from 2% to 3% in 2011/12 implying savings of £275 million across all territorial and special health boards in 2011/12. This compares with achieved savings of £208 million in 2009/10. Robust and deliverable savings plans will be crucial to NHS boards in balancing their finances and releasing cost efficiencies for investment in services.

78. The capital budget in particular will be very significantly affected, with a 15% reduction in capital spending in 2011/12 alone. Capital funding in 2011/12 will be prioritised and focused on a number of major capital schemes including the new Southern General Hospitals in Glasgow and the Royal Victoria Hospital in Edinburgh. In the context of declining capital budgets, new projects are likely to be funded through non-traditional financing routes such as the non-profit distributing (NPD) model. In general the management of major projects will become even more challenging in context of overall funding reductions.

79. The 2011/12 budget states that projects with a capital value of up to £750 million will be financed through the NPD model including the Royal Sick Children's Hospital and Department of Clinical Neurosciences in Edinburgh. Smaller health projects are likely to be financed through the 'hub initiative' which is led by the Scottish Futures Trust. Five hub territories have been established across Scotland; public sector organisations across these hub territories will work in partnership with each other and a private sector delivery partner in a joint venture called Hubco.

80. The Scottish Government decides the level of funding provided to NHS boards and they, in turn, are required to operate within the set funding levels. This means that boards need to make complex decisions about prioritisation of services and resource allocations. These include the shift of the balance of care to the primary care sector and the costs of funding new and continuing initiatives such as waiting times targets, many of which need to be financed from a tighter funding settlement. Major savings are expected to accrue from service redesign, however, these will take time to realise.

81. There are a number of national issues which provide further challenges to financial management within NHSScotland:

- National policy decisions, for example the abolition of prescription charges , the commitment to free personal and nursing care or the scope for making economies in staff numbers or rationalising facilities, are potentially significant for NHSS financial management.
- Staff pay costs are the biggest item of expenditure for NHS boards and absorb much of the increase in funding for the NHS in Scotland. Pressures have arisen as a result of the implementation of a range of commitments including the consultant's contract, the new General Medical Services contract and Agenda for Change. The costs of implementing these contracts have been higher than anticipated, leading to higher than expected increases in staff costs. While pay costs may remain fairly static over the next couple of years, due to the introduction of a pay freeze, the major challenge for NHS boards is how these costs can be managed overall. Incremental drift, in particular, will add significantly to the pay bill.
- Rising drugs costs will continue to be a significant source of pressure particularly with the expansion in prescribing of new drugs approved by the Scottish Medicines Consortium. In 2010/11 expenditure on drugs rose by a further 4.1% from the 2009/10 costs of £1.3 billion.

- The Scottish Government raised the efficiency savings target for NHS boards to 3% from 2% commencing in 2011/12. Only four territorial NHS boards and three Special Boards achieved this level of efficiency savings in 2009/10.
- Approximately one third of the NHS estate will require major upgrading in the medium-term. However, the capital allocations available to NHS boards have been reduced significantly. In the period 2010/11 to 2014/15 the capital budget will be reduced in real terms by 36.7%. Apart from a relatively small number of nationally important projects e.g. the new hospitals at the Southern General site in Glasgow, NHS boards will have to consider other forms of funding such as NDP and the 'hub initiative'.
- The forecast growth in the number of older people in Scotland has implications for health spending. Between 2008 and 2033, the population of working age is expected to grow by 2.2% while in the same period the population of pensionable age is forecast to grow by 31.4%. The Scottish Government estimates that around £4.5 billion is spent on health and social care services for those aged over 65. If services continue to be delivered on the same basis in future, this spending is forecast to rise to £8 billion by 2031. In addition, older people suffer from long term conditions such as dementia and diabetes which are expensive to treat. All these factors will have leading to rising demand for services and increasing costs.
- Existing PFI commitments amount to £120 million per year and are fixed well into the future. There is little scope for NHS boards to make savings against the contracted PFI payments. Alternative sources of funding are being promoted principally the non–profit distributing (NPD) model and the hub initiative led by the Scottish Futures Trust on behalf of the Scottish Government. With these initiatives at a very early stage it is unclear how it will deliver the required infrastructure assets.
- The impact of Equal Pay regulations has led to boards potentially facing additional costs relating to backdated pay increases. By the end of 2010/11, Central Legal Office was again unable to provide any reliable estimate of each board's potential liability. The financial risks relating to this continuing uncertainty about potential liabilities need to be managed by boards.
- The NHSScotland Resource Allocation Committee (NRAC) was set up to review how the NHS budget is shared among the territorial health boards. It recommends improving the way the NHS budget is shared among health boards in Scotland. In total, compared to the existing Arbuthnott Formula, the proposed NRAC changes would redistribute £81.9 million among health boards – this represents 1.2 per cent of the overall budget and may have a substantial monetary impact on some health boards. However, the SGHSCD continues to take a measured approach to implementing NRAC recommendations to avoid creating financial turbulence within the NHSScotland.
- From 1 August 2009, the European Working Time Directive (EWTD) limited the number of hours doctors in training are permitted to work to 48 hours a week on average. Health boards need to monitor the compliance with these regulations and manage the impact on costs of using additional locum cover.

Links to other work

82. Audit Scotland's Financial overview of the *NHS in Scotland (December 2010)* drew attention to the fact that NHS funding is rising less quickly than before but demand and cost pressures continue to increase. The report also highlighted that cost pressures will increase as demand for services grows, and increases in prices, for example drugs, outstrip increases in funding.

83. Audit Scotland also published a report on *Scotland's public finances – addressing the challenges (August 2011)*. This contained a number of key messages for the public sector including NHS bodies. Some of these messages are summarised below:

- All parts of the public sector have less to spend in 2011/12 than in 2010/11, although the level of budget reduction varies significantly among spending areas. Scottish Government funding to the health and local government sectors has reduced by 0.3 per cent and five per cent respectively. Most bodies surveyed have been able to agree a balanced budget for 2011/12. However, there is a risk that savings needed may not be realised during the year. There is also a risk that unforeseen pressures will emerge during the year, which may reduce further the ability to generate savings.
- Public bodies currently face increasing demand and cost pressures for their services and this is likely to continue in the future. An ageing population, the effects of the recent recession and the heightened expectations of the public, all increase the demand for public services. These, together with cost pressures such as maintenance backlogs and existing financial commitments such as annual payments for revenue-financed capital projects, place an additional burden on the capacity of public bodies to provide efficient and quality services at a time when budgets are reducing.
- The need to reduce costs provides public bodies with an opportunity to reform and streamline public service delivery. However, in doing so, bodies must focus on long-term financial sustainability. This requires a clear understanding of the organisation's costs, including how different activity levels affect costs, and a clear methodology for setting budgets based on priorities and the outcomes to be achieved. Strong leadership and governance are vital if actions are to be successful.
- Pay restraint and reducing workforce levels are the most common approaches being taken by public bodies to reduce costs over the next few years. Many bodies have already reduced staff levels through recruitment freezes or voluntary early release schemes and further reductions are planned. Good workforce planning is necessary to ensure that the right people and skills are available to deliver effective public services in the future.
- Public bodies are considering how they can work better together as a way to reduce costs. While a number of initiatives are being planned to increase working together, sharing resources and involving voluntary and private organisations, progress to date has been limited. It is likely to be a number of years before cost savings are realised.

84. Audit Scotland also published other reports that commented on financial matters in the NHS:

- *Using locum doctors in hospitals (June 2010*). The report concluded that the NHS in Scotland could save about 15% of what it spends on locum doctors in hospitals – or about £6million a year – by better planning and procurement.
- *The cost of public sector pensions in Scotland (February 2011*). The report looked at the country's six main public pension schemes. It highlighted that public bodies pay £2.2 billion and employees £810 million a year towards the costs of providing pensions. There are significant cost pressures in all the schemes both in the pensions paid out and the money paid in. Because people are living longer, the schemes are paying out more than anticipated. Growth in the public sector workforce has also increased the number of pensioners. The total amount paid out in pensions has risen by 30 per cent in real terms over the past five years. Major reforms of public sector pensions are planned including higher employee contributions to address the growing pressures on funds.
- *Transport for health and social care (August 2011*). The report found information on costs, quality and people's needs is inadequate. Audit Scotland found that at least £93 million is spent annually on transport for health and social care, but this is likely to be a significant underestimate because it is difficult to identify what is spent in this area. Greater coordination of transport for health and social care, which affects many people across Scotland, could lead to significant improvements and financial savings.

Key risks

85. These include:

Long-term strategy

- The current economic downturn and fiscal squeeze will put increasing pressure on funding. Boards should have robust plans in place to ensure they are able to match the demands of the service with the funding provided.
- Financial planning focuses on annual budgets and does not consider the long-term planning strategy, including the impact of local and national shared services. The board should have short and long-term financial plans. Timescales of savings targets and any financial recovery plans, and how these will be reported, should have been agreed with the SGHSCD.
- The financial planning and monitoring process is not robust and is not based on reliable and accurate cost base and activity data, combined with inadequate identification of significant cost pressures, which may increase the risk of recurring financial deficit. Financial plans should be based on robust base cost and activity data and the budget monitoring system should include a system of budgeting which ensures flexibility and allows accurate and ongoing review to reflect changes in service delivery and local and national priorities.
- The board's financial model is inflexible and is not subjected to sensitivity analysis to deal with variations from the financial plan or unexpected changes in the wider economic

environment, e.g. rising inflation. The board should have clearly identified financial risks within its risk registers and ensure that these are regularly reviewed and effectively managed.

- Boards may no longer be able to provide all services currently available to patients. NHS boards will have to review and prioritise services and ensure that these are aligned with future funding allocations.

Savings plans

- Spending commitments may exceed budgets due to over-optimistic savings plans or unforeseen cost pressures.
- Savings plans are unrealistic and short-term, and do not focus on reducing underlying expenditure on a recurring basis. Savings plans focus on service reduction and do not provide genuine efficiency savings as specified in the Efficient Government initiative. The board should be able to demonstrate that identified savings are robust and deliverable and are closely monitored to ensure they are achieved.
- Saving plans may not be delivered due to a lack of a risk and evidence-based cost reduction strategy. It may also result in inefficiencies remaining within the system.

Capital programme

- Capital funding is insufficient to deliver NHS boards' capital programmes resulting in projects being delayed or cancelled. Boards need to be able to demonstrate that they have reviewed and prioritised capital projects to ensure that sufficient capital is available to fund service improvements. Also, new methods of capital funding are as yet untested and may not deliver planned capital commitments.

Integration of service and financial planning

- Financial and service planning processes, including workforce planning, are not integrated and do not demonstrate that funding has been allocated to key service priorities. The board needs to ensure that funding matches the real pattern of healthcare need and is not distorted by shorter-term decisions on the availability of savings.
- Financial plans, including recovery plans, are not fully 'owned' by key managers across the organisation, including senior clinicians. The board needs to consult with key stakeholders in order to have identified clear service priorities.

Scrutiny and monitoring

- Inadequate financial information is available, impacting on management's ability to effectively monitor financial performance. The board should have an integrated financial system which is used to prepare effective and transparent budgets and subsequent reports on the financial impact of shared services, joint budgets and regional planning.
- Financial management processes do not include measurable outputs and the board is unable to demonstrate value for money from additional investment or changes in service

delivery. The board should be able to show that it has specific output and outcome measures and that performance against them is regularly monitored.

- The board and its committees do not receive regular financial reports which allow them to effectively scrutinise and challenge the financial position and ensure Efficient Government targets are being met. Reports should include sufficient analysis of the financial performance of operating divisions and CHPs/CHCPs.
- There is a lack of financial expertise at board level to provide meaningful scrutiny. The board should be able to demonstrate that members have sufficient support and training.

Partnership working

- Clear accountability arrangements have not been established for partnership working. The board should be able to demonstrate clear lines of accountability and financial processes to manage the move towards joint budgets, investment in CHPs and increased regional planning initiatives, including the requirement to implement formal cost sharing, resource transfer and other funding arrangements.
- Savings from shared support services may not be fully realised and the cost of change may be greater than forecast. There should be evidence that the financial and staff continuity risks associated with shared services are being considered.

Affordability and sustainability

- The affordability and sustainability of the service may be impacted by a range of factors. Boards will need to be able demonstrate that their financial planning and information is responsive to a range of external forces. These include:
  - the lack of effective monitoring and management to deal with the requirements of the EWTD. Boards may face a fine or legal action if appropriate action is not taken to comply with the limits on the number of hours worked by doctors in training over the year
  - the cost of new medicines and technology which, together with a range of new initiatives, means that funds will have to be targeted appropriately. Without this targeting, boards may fail to meet national targets or may not deliver the level of service required by its resident population.

Performance management

Background

86. Current delivery and performance management arrangements for the NHS are based on Local Delivery Plans (LDPs), which are structured around a hierarchy of four key ministerial objectives: health improvement, efficiency, access, and treatment (HEAT) and a range of supporting measures.

87. NHS boards are required to produce LDPs which state their planned levels of performance against each of the key performance measures. These are agreed with the SGHSCD and form the basis for performance monitoring.

88. The HEAT Performance Management system is updated on a monthly basis with the latest performance information at both national and board level. This is available on NHSNet and allows both the SGHSCD and the boards to monitor performance against the key targets on an ongoing basis.[2] Boards' performance against these targets is a key component of the Annual Reviews with the Cabinet Secretary.

89. Boards are expected to monitor and report progress against other local targets and initiatives, including Efficient Government. Quality outcomes measures to support and monitor progress against the Quality Strategy were published in March 2011 and are to be used for national reporting on longer term progress towards the quality ambitions and outcomes. HEAT targets describe the specific and short term priority areas for targeted action in support of the quality outcomes.

90. The Scottish Government's approach to performance management is based on a National Performance Framework and outcome agreements. In support of this, the Scottish Government has developed an electronic tool and website (Scotland Performs) to communicate to the public on Scotland's progress. This includes progress on overall delivery of the administration's purpose for Government, the five strategic objectives for Scotland and other aspects of the outcomes based National Performance Framework.

91. To date, only NHSScotland contributes directly into the website although there is an expectation that all public sector bodies should be able to clearly demonstrate how their activities are aligned with the government's overarching purpose through the National Performance Framework. Where a public sector body is a statutory community planning partner, there is a further requirement that they sign up to local Single Outcome Agreements which are designed to help align public sector activity with the Government's national priorities. Good performance management arrangements will be key to supporting this process, by clearly spelling out the actions each partner will take to support the delivery of outcomes.

[2] This is only available on NHSNet, so there is no reference in the PRF.

92. The Scottish Government's Quality and Efficiency Support Team (QuEST) works with NHS boards to support the delivery of quality and efficiency and provides support through benchmarking, data development and the use of toolkits. High volume, high cost services and key priority areas are selected for review with the aim of improving levels or performance. Current programmes include; 18 week service redesign and transformation, cancer performance support team and the application of strategic LEAN methodologies. A number of benchmarking tools have been developed for NHS boards including: a Whole System Balanced Scorecard with a range of 31 indicators; Better Quality Better Value indicators provides analysis on variation in performance among NHS boards, hospitals and specialties; the Mental Health Dashboard compares aspects of performance in relation to patient experience, use of resources, the appropriateness of service provided; and a National Theatres Implementation group has been overseeing a theatre benchmarking project.

93. NHS boards are expected to reduce their greenhouse gas emissions. The Scottish Parliament passed the Climate Change (Scotland) Act in July 2009. The Act requires a reduction in greenhouse gas emissions of 80 per cent by 2050. The Act places a duty on all public bodies, including the NHS boards, to act 'in the way best calculated to contribute to the delivery' of targets to reduce greenhouse gas emissions. It also allows ministers to require public bodies to report on their performance. In addition, the mandatory UK-wide CRC Energy Efficiency Scheme came into force in April 2010 and affects most area health boards. It is a cap-and-trade system in which participating organisations will initially buy permits to emit carbon dioxide on the basis of their energy consumption. These permits will be tradable so that organisations that reduce their carbon dioxide emissions will be able to sell their permits to organisations that have been less successful. Although the scheme began in 2010, the price mechanism of the scheme will not take effect until 2011/12 with the first sale in 2012.

Links to other work

94. As part of its programme of work on the audit of Best Value, Audit Scotland has developed a toolkit on performance management. .

95. Audit Scotland published Improving energy efficiency in December 2008 and this study included NHS bodies. A follow-up study was published in December 2010.

Key risks

96. These include:

Embedded local performance management

- Performance management and reporting is not given sufficient priority at appropriate levels in board structures and the arrangements do not ensure that performance management leads to continuous improvement. Boards focus on national targets to the detriment of ensuring that they are delivering sustainable local services. The board should be able to demonstrate that:

- performance management is an integral part of the board's strategic, operational, financial and patient-focused planning process and is clearly considered during service redesign projects
- the performance management system leads to continuous improvement in service delivery, eg by developing action plans following local or national reviews and following up action plans to ensure progress
- the performance management system considers the economic, efficient and effective use of resources
- performance management arrangements consider the quality of care, ie outcome rather than output focused
- there is clear accountability and responsibility for delivery.

Core performance management principles

- The board's performance management systems do not incorporate recognised core principles of performance management. The board should be able to demonstrate that:
  - performance management, measurement and accountability systems cover the whole organisation, not simply areas covered by HEAT targets
  - performance management arrangements support full alignment with the National Performance Framework
  - the board provides an accurate and timely view of activity and outputs that supports progress to well-defined outcomes
  - the board links input (finance and staff) to outputs (performance against targets) and quality of care
  - benchmarking data is collated, shared and used appropriately
  - there is regular review and discussion of this data at monthly (or more frequent) scrutiny meetings led by chairs and board members and/or by senior management, focusing on the data and actions to improve performance
  - there is active follow up of the actions identified from the data and the discussion.

Local Delivery Plan targets

- The board does not monitor and report on all the key targets outlined by the SGHSCD. The board should be able to demonstrate that:
  - the performance management system provides the information required to monitor progress against the LDP key targets
  - performance against the LDP key targets is regularly reported to the board
  - action plans for improvement against the LDP key targets are developed, with clear ownership and timescales, and these action plans are followed up regularly.

Partnership working

- A joint performance management framework is not in place resulting in poor and untimely decision making. CHP/CHCPs are unable, therefore, to demonstrate that they have been effective in shifting the balance of care from acute to community settings based at a local level and in improving local health services. The NHS board should have procedures in place for ensuring that:
  - key performance measures have been identified, and defined, for areas of joint working and these are regularly monitored and reviewed
  - performance management reporting lines and timescales are clear
  - performance monitoring arrangements are sophisticated enough to provide evidence of improved service delivery as a result of partnership working, including through SOAs.

Efficient Government

- The board does not monitor cash-releasing savings against Efficient Government targets. The board should be able to demonstrate that it has systems that allow it to monitor and record cash-releasing savings.

Public reporting

- Boards do not properly report performance against key targets to the public and other external stakeholders, including detailed analysis of performance against key targets. The board should demonstrate public accountability through a comprehensive analysis of performance in the operating and financial review accompanying the financial statements and subsequently the annual report.

Reducing greenhouse gas emissions

- The board does not have a plan to reduce its greenhouse gas emissions and systems in place to report its performance, as may be required by the Scottish Government under the Climate Change (Scotland) Act. The board should be prepared for the introduction of the CRC Energy Efficiency Scheme in 2011.

Capacity to deliver

Background

97. NHSScotland is going through a period of substantial change as it responds to developments in healthcare, demographic movements (particularly the increase in the elderly population), political and administrative initiatives such as the removal of prescription charges, and the effect of the Scottish Spending Review and draft budget for 2012/13. These pressures impact on the organisational capacity of boards to address a whole range of developments, all of which are important for the successful delivery of NHSScotland's core objectives.

98. As the economic downturn continues to have its effect there could be implications for NHS staffing levels, although currently the Scottish Government has re-affirmed that the policy of no compulsory redundancies continues to apply within the NHS in Scotland for the next year. At the same time, the Scottish Government expressed its wish to reduce the number of senior managers within the NHS in Scotland by 25% over the next four years.

99. *Better Health, Better Care* is the core strategic change programme for NHSS. It recognises that efficiency improvements are necessary to achieve the goal of providing better access to local healthcare services, allowing the people of Scotland to sustain and improve their health and support the ethos that the people of Scotland and NHSS staff should be 'co-owners' of the service. As previously noted, this has now been supplemented by the Healthcare Quality Strategy.

100. With an increased focus on flexible, local delivery, particularly in rural areas and areas of deprivation, it is clear that changes will be required in the way in which services are currently delivered in the NHS. Boards will have to reassess their priorities and current working practices to design local sustainable services which fulfil the government's requirements, secure best value and support local, frontline services, with key service change proposals being subject to independent scrutiny. Also, a National Scrutiny Group was set up by the Scottish Government in August 2010, whose remit includes reviewing NHS board's workforce plans. Boards will therefore have to assess their ability to deliver on these key issues with reference to management, workforce, infrastructure, information management and financial capacity.

101. The NHS faces a number of key challenges:

- ensuring that there is sufficient management capacity to deliver the change agenda and deliver improved services successfully
- workforce planning should ensure that NHS in Scotland has the right staff in the right place at the right time in order to deliver high-quality care and services to the people of Scotland. To achieve this, the workforce needs to be fully aligned with service delivery that is both affordable and sustainable
- services could be disrupted as a result of industrial action by public sector unions in the wake of pay restraint and proposed reform of public sector pension schemes

- there remains a risk of a significant outbreak of an influenza pandemic during the 2011/12 period and boards require to ensure that they are able to respond appropriately in the face of heavier demands on their services at a time of pressure on staff availability and a range of increasing costs
- the impact of major pay modernisation contracts and of Modernising Medical Careers will continue to affect boards, and the monitoring of doctors hours against the EWTD must continue
- equal pay claims lodged following on from the Equal Pay Act (2004) may result in additional financial pressures for boards, and back pay for any changes may apply. The NHS Central Legal Office is instructed by the Management Steering Group of the NHSScotland and coordinates the legal response of NHSScotland to this issue in order to help establish consistency in how equal pay claims are handled across Scotland
- as part of the Efficient Government programme, boards need to take action that will achieve the SGHSCD's key savings targets
- ensuring asset management strategies are regularly reviewed and that the infrastructure is in place to deliver the required services to the necessary standards. This will be very challenging in the light of the October 2010 spending review.

102. Circular CEL (2011)26 set out the strategic direction for further developing information assurance capability and embedding it within NHS Scotland. The strategy sets out four areas and the actions required to deliver successful information assurance:

- Leadership and governance should ensure that responsibilities are assigned from the board downwards and that information assurance is understood, visible and accessible and embedded in the culture of NHSScotland. To achieve this, boards should review local arrangements to ensure clear lines of responsibility and accountability.
- A proportionate information risk management approach should be embedded in the organisation and aligned to the board's corporate risk management framework.
- Policy and operations should be clearly articulated, based on best practice standards and continue to evolve to reflect current priorities. Boards should develop and support appropriate training for staff and implement information protection software to strengthen their systems.
- Monitoring and compliance mechanisms should provide positive assurance that board policies are implemented effectively and achieving the desired outcomes.

103. Boards should have a robust financial management framework in place which includes short and long-term financial plans, savings targets, financial recovery plans, financial risk management, budget monitoring and financial scrutiny at all levels. This will ensure that boards have the financial capacity to deliver the required level of service. This has become even more pressing during the current economic downturn and is discussed further within the chapter on Financial management and affordability.

Links to other work

104. Audit Scotland published a report on the *Review of telehealth in Scotland (October 2011)*. This report looks at how the telehealth service is providing care to patients at a distance, using a range of technologies such as mobile phones, the internet, digital televisions, video-conferencing and self-monitoring equipment. This could include a consultation between a patient and a doctor being carried out at different locations using video-conferencing. The report says that the NHS in Scotland should do more to consider telehealth when introducing or redesigning services. It provides an opportunity to treat patients in news ways, and to help manage rising costs and demand.

105. Audit Scotland has also published studies on Transport for health and social care in August 2011, *Scotland's public finances – addressing the challenges (August 2011) and the Review of Community Health Partnerships* in June 2011. All of these have implications for managing NHS Service delivery, particularly in the context of stretched resources.

106. As part of developments in the audit of Best Value, Audit Scotland has developed a range of audit toolkits which are of relevance:

- Vision and strategic direction
- Information management
- People management
- Financial management
- Asset management

Key risks

107. These include:

Leadership and management capacity

- The board does not demonstrate the clear vision and leadership necessary to achieve the culture change required to deliver a positive change in health outcomes, and to do so in the context of additional financial pressures. The board should have developed and communicated a clear vision of the future which is outcome focused, flexible and, if necessary, commit to stopping doing things that have not made the difference intended.
- Poor programme and project management results in late or inefficient and ineffective project delivery for key redesign projects. The board should have assessed its management capacity to deliver its vision and programmes of service improvement, including executive leadership, risk and change management, programme and project management requirements, and workforce requirements.
- Management capacity is insufficient to meet the requirements of planning and managing the change agenda, and implementing learning and training developments for staff. Involvement with managing change and implementing new contracts means that management time is taken away from the main task of delivering improved services. The board should be able to demonstrate that this has been considered at a local level.

Workforce capacity

- Workforce strategies are not fully integrated into all service activities and planning at every level, ie local, regional, and national. The board does not have sufficient processes in place to accurately estimate and plan for future workforce requirements, control its recruitment and retention activities or, in a downturn period, to manage any reduction in staffing numbers that may be judged necessary. The board should be able to demonstrate that it has:
  - quantified workforce requirements to resource the NHS in the short, medium and longer-term, taking into account planned changes in service redesign, working practices, training, service delivery and resources
  - arrangements to monitor staff turnover rates and take action to address significant concerns
  - produced and is able to take forward a formal workforce plan
  - plans in place to develop nursing workforce planning in line with the requirements of the Chief Nursing Officer's Letter of August 2007, *Implementation of Nursing and Midwifery Workload and Workforce Planning Tools and Methodologies*
  - an established staff appraisal system which seeks to identify training and development needs, and has sufficient resources to meet these needs
  - put in place all necessary governance arrangements and agreed severance processes where there is to be a reduction in staff numbers
  - joined up workforce plans with financial and service plans.
- Workforce information is not sufficiently robust or accurate to enable the construction of credible evidence-based decisions to support workforce management, including planning and development. This includes work in the development of team-working, delivery of care, skill mix and career development. The board should be able to demonstrate that:
  - data on workforce is sufficiently detailed and accurate to meet the requirements of workforce planning, SWISS, the Equality Act 2006 and the staff governance standard
  - continues to monitor doctors' hours in accordance with Modernising Medical Careers (MMC) and the European Working Time Directive
  - contingency plans are in place to address any deficiency in workforce data.
- The board does not have procedures in place to assess and demonstrate how it is delivering the benefits of pay modernisation. The board should be able to demonstrate that:
  - it is actively using pay modernisation as one of the drivers for change
  - it is considering value for money as part of this process
  - it has procedures in place to enable them to produce Pay Modernisation Benefits Delivery Plan progress reports to the SGHSCD and to meet the requirements of HDL(2005)28.

- There is a risk that the board does not have plans to manage the risks of equal pay claims. The board should be able to demonstrate that it has identified the risk of possible equal pay claims, including those relating to potential age discrimination and has put in place plans to deal with such claims.
- There is no robust system in place to provide an accurate record of staff sickness absence. The board should be able to demonstrate that a system is in place to allow it to measure the success of initiatives designed to control sickness absence levels.
- Planned reductions in the NHS workforce in Scotland pose a number of risks, including:
  - reduced leadership skills and professional resource as a result of losing essential skills and corporate knowledge particularly amongst senior manager grades
  - reduced quantity and quality of service delivery created by staff shortages in key service areas caused by unmanaged workforce reductions
  - lower staff morale and increased levels of sickness absence due to increased workload and lower reward packages, and the negative impact on remaining staff created by workforce reduction.

Infrastructure capacity

- Inadequate procedures exist to identify and dispose of redundant assets and manage staff redeployment resulting from continued service redesign. The board should operate an effective asset management strategy and workforce plans should take account of the consequences of service redesign.
- Significant reductions in capital funding may cause boards to defer or even cancel new projects designed to improve service delivery or patient care.

Information management capacity

- The local eHealth strategic plan does not recognise the information needs of all divisions and partner organisations. Arrangements should be in place to ensure that the strategic plan is regularly reviewed to recognise changing information requirements and national programmes.
- NHS boards fail to fully address the requirements of the information assurance strategy and cannot be confident that all information is held securely, appropriately maintained and is available when necessary.
- Funding streams and expenditure budgets for eHealth programmes are not in place. The board may not be able to release resources to support the eHealth Strategy without compromising clinical developments. The board should be able to demonstrate that that it has addressed these planning and funding issues.
- Continuity and contingency plans are not complete or tested on a regular basis. Arrangements should be in place to ensure that business continuity and contingency plans for all critical areas are developed, tested and reviewed. Contingency plans should include data storage and sharing data between partners.

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Glossary

Agenda for Change	A UK-wide new pay system for all NHS staff with the exception of doctors, dentists and most senior managers. The new system aims to standardise conditions of service for staff.
Annual review	Annual review of a board's performance against its key performance measures and targets, led by the Cabinet Secretary for Health and Wellbeing. The HEAT targets as well as independent assessments of performance by, for example, local partnership forums form the basis of this review.
Better Health, Better Care	Launched in December 2007, with the aim of the plan being to 'help people to sustain and improve their health, especially in disadvantaged communities, ensuring better, local and faster access to healthcare'.
Caldicott Guardian	Senior manager within a board charged with responsibility for ensuring the highest standard of patient confidentiality when obtaining and processing personal health information.
Capital receipts	Funding received from the sale of capital items (ie, items over £5,000) to be used on revenue, or day-to-day expenditure. This may or may not be associated with a particular capital scheme.
Capital Resource Limit (CRL)	The amount of money that an NHS board is allocated to spend on capital schemes in any one financial year.
Cash-releasing savings	Where a saving is realised because the organisation or function delivers the same service using less money. For example, by delivering support services differently.
Cash requirement	The amount of cash an NHS body needs to support its operational activities during the year.
Clinical governance	Arrangements put in place to ensure safe and effective healthcare. NHS QIS reviews boards' clinical governance arrangements.
Community Health Partnership (CHP)	CHPs aim to work in partnership with local authorities, the voluntary sector and other stakeholders such as the public, patients and carers to ensure that local population health improvement is placed at the heart of service planning and delivery. They are devolved from the board and provide a focus for the integration between primary care and specialist services and with social care.
Corporate governance	Arrangements put in place to ensure proper management and use of resources.

Delivering for Health	Published in November 2005, this provides a strategic long-term programme of action and a framework for service change across NHSScotland. It is a programme of action designed to transform the NHS by improving quality and efficiency and by promoting the integration of services.
Equal pay	The Equal Pay Directive made it clear that all discrimination should be eliminated from all aspects of remuneration. The NHS in Scotland has received a number of claims for equal pay in which additional pay back is sought, arising from the requirement for equal pay.
European Working Time Directive (EWTD)	European law seeking to protect the health and safety of workers. It was enacted into UK law in 1998 as the Working Time Regulations. The Working Time Directive limits the number of hours that doctors are allowed to work over an average week.
Financial balance	Where income received is equal to expenditure on an ongoing basis.
Governance	The framework of accountability to users, stakeholders, and the wider community in which the organisations take decisions, and lead and control their functions, to achieve their objectives.
Health, Equality, Access, Treatment (HEAT) targets	A range of key performance targets agreed between boards and the SGHSCD. Performance against these standards is reported with the board's annual operating and financial review and is discussed at the annual review.
Healthcare Environment Inspectorate (HEI)	Inspectorate established in April 2009 which aims to reduce the risk of healthcare associated infections in acute hospitals through assessment, inspection and reporting.
Healthcare Improvement Scotland (HIS)	HIS is the lead organisation in improving the quality of healthcare delivered by NHSScotland. It sets clinical and non-clinical standards to improve services and reviews boards' performance against these standards. It was established in April 2011 and replaces NHS Quality Improvement Scotland and some of the previous functions of the Care Commission, particularly regulation of the independent healthcare sector.
Healthcare Quality Strategy	Introduced in 2010 by the Scottish Government. A development of Better Health, Better Care, focused on making further improvements in the quality of care.
Independent Scrutiny Panels	Introduced by Scottish Government to consider proposals for major changes in local NHS services in Scotland.

Joint Future Agenda	The Joint Future Unit was set up by the Scottish Government in 2000 to provide better and more integrated Community Care services by developing joint working between local authorities, NHSScotland and other organisations.
Local Delivery Plan (LDP)	These assist the boards and the SGHSCD in managing the delivery and performance of health services. They contain key performance targets and measures.
Managed Clinical Network (MCN)	An MCN comprises clinicians from all backgrounds and sectors in the NHS in a given clinical area, for example stroke care or coronary heart disease, working across the boundaries between the professions, and between primary and secondary care.
Modernising Medical Careers (MMC)	A UK-wide initiative aimed at reforming postgraduate medical education and training. It involves providing more flexible training pathways that are tailored to meet service and personal development needs as well as being compatible with the Working Time Directive.
National Fraud Initiative (NFI)	A sophisticated data matching exercise which matches electronic data within and between participating bodies to prevent and detect fraud.
NHSScotland Resource Allocation Committee (NRAC)	The committee was established in 2005 to improve the method of dividing the NSH budget among NHS boards.
Private Finance Initiative (PFI)	The UK Government's initiative to encourage the development of private finance in the public sector.
Public Private Partnership (PPP)	A generic term for projects involving both the public and private sectors. The involvement can be to varying degrees and the partnership can take different forms. PFI is one example of PPP.
Revenue Resource Limit (RRL)	The amount of money an NHS board is allocated to spend on day-to-day operations in any one financial year.
Scottish Futures Trust	The Scottish Futures Trust will develop the expertise and investment models for a range of public sector infrastructure projects including new schools, hospitals and transport infrastructure projects for Scotland.
Scottish Government Health and Social Care Directorates (SGHSCD)	The SGHSCD (previously known as the SGHD) is responsible both for the NHS in Scotland and the development and implementation of health and community care policy. The SGHSCD oversees the work of the 14 territorial health boards and nine special health boards.
Scottish Patient Safety Alliance (SPSA)	The alliance was set up by the Scottish Government Health Directorate in 2007. The alliance brings together the Scottish Government, NHS QIS, health boards and special boards, professional bodies, patient experts and other groups.

Scottish Patient Safety Programme (SPSP)	The programme was set up by the Scottish Patient Safety Alliance in 2007. HIS coordinates the programme which aims to use evidence based tools and techniques to reduce healthcare associated infections, reduce adverse surgical incidents, reduce adverse drug events, improve critical care outcomes, improve care received on general wards and improve the organisational and leadership culture on safety.
Scottish Workforce Integrated Strategic System (SWISS)	This system aims to provide accurate and consistent information about the NHSScotland workforce.
Single Outcome Agreements (SOA)	Single Outcome Agreements are agreements between the Scottish Government and each council which set out how each will work in the future towards improving national outcomes for the local people in a way that reflects local circumstances and priorities.
Time-releasing savings	Efficiencies which do not release cash but allow frontline services to deliver more or better services with the same money. For example, through reducing sickness absence.
Agenda for Change	A UK-wide new pay system for all NHS staff with the exception of doctors, dentists and most senior managers. The new system aims to standardise conditions of service for staff.
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Priorities and Risks Framework

A national planning tool for 2011/12 NHSScotland audits

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