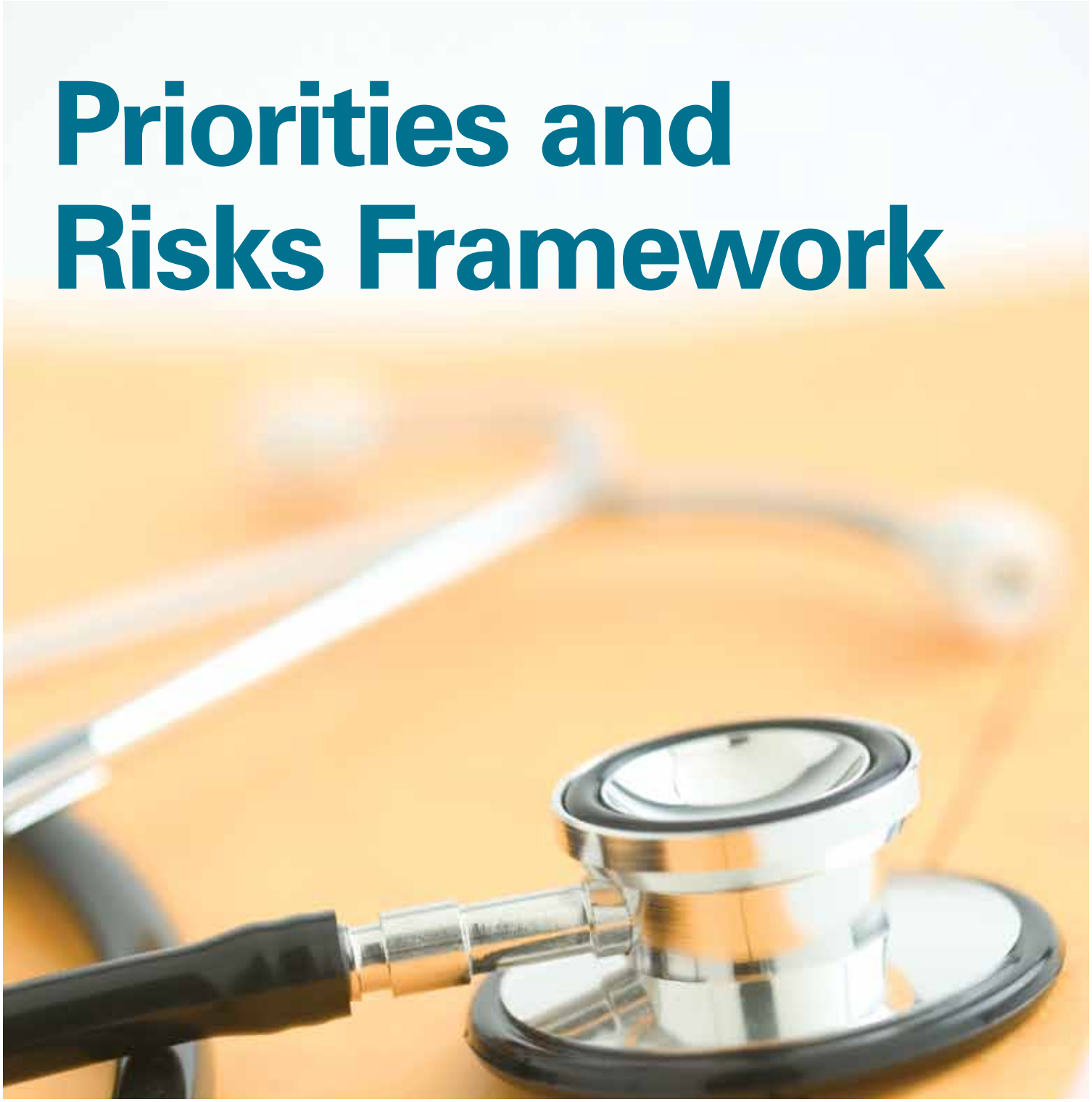
Priorities and Risks Framework



AUDIT SCOTLAND

A national planning tool for 2010/11 NHSScotland audits

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Auditor General for Scotland

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- directorates of the Scottish Government
- 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 2009. The Scottish Government's healthcare initiatives, as set out in the *Better Health, Better Care* Action Plan in December 2007, continue to develop. In May 2010, the Scottish Government published its *Healthcare Quality Strategy for NHSScotland,* as a development of *Better Health, Better Care,* 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 will involve 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 been significant changes in the public financial environment since the last PRF including the implications of the change in National Government after the General Election of May 2010 and the national Comprehensive Spending Review of October 2010. Although spending decisions in non-reserved areas are a matter for the Scottish Government, there will be a significant impact on the overall level of funding available for public services in Scotland in the coming years. The 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. Users of the PRF should be aware of the pending Scottish Parliament election in May 2011. The outcome of the election may result in policy shifts which could result in refocusing of resources and activities. However, the key priorities and risks identified in the PRF are expected to continue to be relevant during the currency of the document.

4. The substantively reviewed PRF of October 2008 (as revised in October 2009) was intended to serve for a three-year period, and largely it continues to do so. This 2010 edition should be seen as an update to that document rather than as a wholly new product.

Audit approach

5. 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.

6. 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?

7. 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. Separate PRFs are prepared for the National Health Service, local government and central government. Each PRF identifies the key national initiatives and priorities facing clients in the coming year and the main risks to their achievement.

8. 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?

9. Sector specific PRFs are developed, generally annually, by multi-disciplinary groups from Audit Scotland and its stakeholder groups. This 2010 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?

10. 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.

11. 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.

12. 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 NHS Quality Improvement Scotland (NHS QIS) (Healthcare Improvement Scotland from April 2011) in relation to clinical governance – with other areas addressed through the monitoring of actions taken by management. Auditors meet with NHS QIS to share intelligence and work plans.

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

13. 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.

Current developments – best value

14. Audit Scotland is continuing to develop its approach to the audit of best value and continuous improvement in the wider public sector, including NHSScotland. Best Value (BV) duties apply across the public sector. In the health service, all NHS board chief executives and the chief executive of NHSS are accountable for the delivery of BV. Work carried out by auditors under the PRF will help inform audit work on BV.

15. There have been significant developments in Audit Scotland's approach to the audit of Best Value since the last PRF in October 2009. Audit Scotland has developed the Best Value 2 approach in local government, and the principles of this approach are being extended into the Health and Central Government sectors. We are adopting a Best Value audit framework that is consistent across all sectors, although the application will vary to reflect the differing accountability arrangements. This focuses on the corporate function of a public body and an assessment of its performance (Exhibit 1).

Exhibit 1: Framework for a BV audit of a public body

16. Audit Scotland is committed to ensuring that BV auditing across the public sector adds value to existing arrangements, is proportionate and risk-based. Specifically we aim to:

    - report on the delivery of outcomes for people who use services
    - protect taxpayers' interests by examining use of resources
    - put an increasing emphasis on self assessment by public bodies with audit support and validation
    - work collaboratively with NHS QIS to ensure our work is aligned and prevent duplication.

17. The building blocks for a BV assessment of an NHS board are already in place. Public reporting on an NHS board includes:

    - an annual review held in public and chaired by the Cabinet Secretary for Health and Wellbeing. Members of the public can ask questions of the board at this review

- an annual audit which is based on key priorities and risks in the sector. Final audit reports are considered at NHS board meetings and are published on Audit Scotland's website
- national performance audit reports on health services carried out by Audit Scotland for the Auditor General. These are presented to the Parliament's Public Audit Committee
- an annual overview report on the whole of the NHS in Scotland, which builds on the annual audit reports and is presented to the Parliament's Public Audit Committee
- short reports on the accounts where the Auditor General wants to bring issues arising from the accounts to the attention of Parliament
- NHS QIS assessments of clinical governance; risk management; and reviews against clinical standards. These reports are published and are available on NHS QIS website.

18. Given the range of reports on the health service, our aims are to coordinate these more effectively and develop our audit approach to ensure that all the BV principles are covered and reported on over time.

19. To this end, Audit Scotland has developed a range of audit toolkits to cover the key 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.

20. 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 .

21. The auditors' annual audit report will make reference over five-year period of the audit appointment to specific work on BV and will form part of the evidence available for the annual reviews of each NHS board. The compilation of the annual audit report will be, to a substantial extent, informed by work undertaken in light of the PRF document.

Service redesign and sustainability

Background

22. 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.

23. 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 which can be set up by the Cabinet Secretary to oversee major service redesign decisions taken by individual boards. These panels have already reviewed revised proposals for the reconfiguration of emergency care within Lanarkshire and Ayrshire, proposals for changes to NHS services in the Clyde area and assessed proposals by NHS Dumfries and Galloway to redesign healthcare in the region.
    - 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 by 2011.
    - The government is changing the funding mechanisms for large capital projects within the public sector, replacing PFI/PPP arrangements with the Scottish Futures Trust.
    - The government has also introduced a new Patient Rights (Scotland) Bill to the Scottish Parliament in March 2010. This Bill is currently at Stage 1 and this process is due to be completed by 19 November 2010.

24. 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 2010/11 and future years. Budget pressures on Local Authorities and on the voluntary sector could also have a consequential impact on NHS resources.

25. Current population demographic forecasts reinforce predictions of an ageing population over time. Current projections suggest that by 2033 the Scottish population is projected to age markedly with the number of people in the 60 plus age bracket increasing by 50 per cent from 1.17 million to 1.75 million, with a significant increase (84 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.

26. 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 the 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] *Scotland's Population 2009, The Registrar General's Annual Review of Demographic Trends,* General Register Office for Scotland, 2010.

Links to other work

27. 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. Our report on *Scotland's public finances: preparing for the future*, which was published in November 2009, stated that the Scottish public sector needs much better information that links its spending with actual service delivery, costs and performance. We also published an *Improving Public Sector Efficiency* report in July 2009.

28. 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.

Key risks

29. 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 Directorates (SGHD) 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 three to five 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, eg 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

30. 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 and to address local needs.

31. *Delivering for Health* (2005) introduced Community Health Partnerships (CHPs) as the main vehicle for improving health services at a local level. The Scottish Executive introduced CHPs from 1 April 2005 with some NHS boards developing Community Health and Care Partnerships (CHCPs). CHPs primarily provide a focus for integration between primary care, acute care and social care, building on the earlier initiatives, in partnership with local authorities and the voluntary sector. Although local arrangements for CHPs/CHCPs vary across Scotland, there is scope for significant amounts of public funds to be managed through partnerships. It is therefore important that good governance systems are in place.

32. 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 a new Healthcare Quality Strategy in May 2010. This Quality Strategy is a development of *Better Health, Better Care* and states as one means of attaining its quality ambitions 'working together across NHSScotland, with partners in the Public Sector and Third Sector'.

33. 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. Single Outcome Agreements (SOAs) were established for local government for 2008/09 and extended to Community Planning Partnerships (CPPs) from 2009/10. NHS boards, through the CPPs, require to engage with local authorities as SOAs evolve. CHPs and other partnerships are responsible for delivering an increasing number of services in many areas. SOAs commit partners to delivering outcomes that they cannot achieve alone and increases the focus on effective partnership working.

34. Community planning partners, including the NHS, must sign up to the whole SOA, rather than just parts of it. This includes a commitment to reviewing their existing structures, processes and

deployment of resources so that they support the delivery of outcomes in all possible ways compatible with their duties and responsibilities. These changes have been accompanied by the removal of ring-fenced funding arrangements from local authorities. 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.

35. 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. Boards will self assess against this for the first time in 2010/11.

Links to other work

36. In 2006/07, Audit Scotland carried out a number of reviews of CHPs/CHCPs across Scotland. These reviews showed that CHPs/CHCPs were at an early stage of development and that there was a need to demonstrate a planned and effective transfer of resources from the acute service to primary and community care. Audit Scotland is currently carrying out a national performance audit of CHPs/CHCPs with publication planned for 2011. This audit will examine whether CHPs are achieving what they were set up to deliver and whether they are contributing to shifting the balance of care from hospital settings to the community and improving the health and quality of life of local people. It will also examine CHPs governance and accountability arrangements and assess whether CHPs are managing their resources efficiently.

37. Audit Scotland's national cross-cutting report *Scotland's public finances: preparing for the future* highlighted the need for strong and effective partnership working. NHS boards and councils in many areas have increasingly been working together to plan, commission and deliver local services.

38. As part of its programme of work on the audit of Best Value, Audit Scotland developed a toolkit on partnership working. This was applied to certain NHS bodies during 2009/10 and covered a number of key issues including governance, the involvement of communities in the partnership process, performance measures and delivering outcomes.

39. Audit Scotland in its 2008/09 overview report noted that there had been some difficulties in agreeing resource transfer monies, an example of the problems boards faced in developing financial relationships with their partners through pooled or joint budgets. The SGHD is working with COSLA to review current arrangements and guidance for resource transfer.

40. The SGHD is leading a national Integrated Resource Framework (IRF) project. 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. The project has two phases. The first phase

involves partners mapping their current activity levels and costs. Four areas have completed the mapping exercise and a further nine NHS boards and 12 councils are engaged in mapping their data. The second phase involves four areas testing different approaches to joint planning and investment decisions using the information from phase 1. Results so far indicate variation in expenditure per head of population and inequitable access to services within and across CHP boundaries. It also identified variation in efficiency of resource use.

Key risks

41. These include:

Commitment and leadership

- 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

42. 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.

43. 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.

44. 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.

45. *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.

46. 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, in June 2009, Fife, and Dumfries and Galloway Health Boards became the first two pilots, with board members elected in June 2010. 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.

47. On 1 April 2011, Healthcare Improvement Scotland (HIS) will begin operating. It will take on the functions of NHS QIS and the regulation of Independent Healthcare function currently undertaken by the Care Commission. The Scottish Government released a discussion paper in August 2010 to provide the NHS in Scotland with an opportunity to contribute to the development of revised and updated guidance for governance arrangements in the light of the establishment of HIS and the Quality Strategy.

Governance

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

49. **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.

50. **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.

51. 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.

52. **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 will be taken over by HIS. Clinical Governance is also covered in the chapter on Patient Safety and Clinical Governance.

53. **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.

Scrutiny

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

55. **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.

56. **External scrutiny**. External scrutiny includes external audit, inspections by NHS QIS/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

57. 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 was applied to a number of NHS bodies during 2009/10 based on local risks and priorities. A toolkit has also been prepared on governance and accountability.

58. 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.

Key risks

59. 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).

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 by the Cabinet Secretary 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.

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 SGHD
    - 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 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 NHS QIS/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.

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 show that it makes use of the Audit Scotland self-assessment tool to review governance arrangements in CHPs. The findings from the self-assessment should be reviewed and an action plan of improvements developed. A joint risk register and arrangements for monitoring it should 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.

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

60. 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.'

61. Currently, in relation to patient safety, there are national HEAT targets to: have reduced MRSA rates by 30 per cent by 31 March 2010, and by a further 15 per cent by 31 March 2011; reduce the rate of Clostridium difficile Associated Disease (CDAD) among patients aged 65 and over by at least 30 per cent by 31 March 2011. In 2011/12, there will be a small number of new targets to replace targets met in 2010/11, and to provide greater alignment with the quality strategy.

62. NHS Quality Improvement Scotland (NHS QIS, but becoming NHS Healthcare Improvement Scotland from April 2011) has lead responsibility for reviewing boards' performance in relation to patient safety, and for working with boards to improve patient safety. Audit Scotland and NHS QIS have 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.

63. Auditors should meet with NHS QIS as part of their risk assessment so they know what work NHS QIS 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 NHS QIS as far as possible, and should also share their intelligence with NHS QIS to inform their work. Auditors' work should be limited to satisfying themselves that the board is taking action to address any concerns identified by NHS QIS and to continuously improve.

64. Patient safety is at the heart of clinical governance and risk management. NHS QIS published national standards for clinical governance and risk management in October 2005 and published its national overview of performance against the standards in October 2007. All boards received local reports following their own reviews. NHS QIS has agreed with the Scottish Government that it will review compliance with the standards at a strategic level, in each NHS board, on an ongoing basis. The second round of review visits took place between May 2009 and May 2010 although the future approach is under consideration. Local reports have been produced for individual boards on a rolling basis, and a further national overview of performance against the standards is expected to be published in November 2010. One of the HEAT targets for 2009/10 was that boards should have shown improvement against the clinical governance and risk management standards in the period since the initial review.

Scottish Patient Safety Programme

65. The SGHD 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. This programme is being coordinated by NHS QIS, and its aims are to systematically improve the safety and reliability of hospital care throughout Scotland.

66. 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.

67. 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 SGHD or NHS QIS.

68. Boards submit information on progress against national measures, with supporting narrative, to the Institute for Healthcare Improvement (NHS QIS' 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.

69. The SPSP has been implemented initially in acute hospitals in all territorial boards and the GJNH, but is intended to be 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 is to be established in NHS boards by end December 2010. The Safety Improvement in Primary Care Programme also started in November 2009.

Healthcare Associated Infection

70. The Healthcare Environment Inspectorate (HEI) was set up in April 2009 as a new inspectorate based within NHS QIS. 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. All first inspections carried out September 2009 to September 2010 were announced, however the year 2 programme will be a mix of announced and unannounced inspections. NHS boards are expected to produce improvement plans following local inspections.

71. 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.

72. 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.

73. 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. A 2009/10 HEAT target required boards to introduce and comply with local antimicrobial policies by 2010.

Use of controlled drugs

74. 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

75. NHS QIS has responsibility for reviewing boards against the national clinical governance and risk management standards and for coordinating the SPSP.

76. 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. HEI has carried out its first inspection programme for September 2009 to September 2010, and has published results on its website.

77. Audit Scotland has completed the following reviews in 2010:

    - *Review of orthopaedic services*, including a review of mortality rates and infection rates. This report was published in March 2010 and included recommendations for boards.

    - *Using locum doctors in hospitals*, this report was published in June 2010 and includes patient safety issues and clinical governance arrangements.

Key risks

78. Auditors should review NHS QIS reports and, if necessary, meet with NHS QIS 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 and the findings from external reviews, 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 local and national reports and standards that relate to patient safety, such as reports and standards issued by NHS QIS, 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

79. Scotland's economy has been adversely affected by the recent economic downturn. The pressure on the public sector, in particular, will intensify as a result of the measures announced in the UK Comprehensive Spending Review in October 2010. 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 declining funding for investment, increasing expenditure growth, the need to identify and deliver significant recurring cost savings, and the financial strain in delivering nationally determined service targets.

80. The Comprehensive Spending Review will inform the Scottish Government's plans for the years from 2011/12 to 2014/15. The climate in which the spending review will take place will be very different to that of 2007. The Auditor General in a recent BBC interview said that the public sector faces *"a long, hard financial winter*". In October 2010, the Treasury estimated that, by 2014/15, the overall Scottish Departmental Expenditure Limits would decline by 10.6 per cent in real terms when compared with a 2010/11 baseline.

81. The Scottish Government recently published the findings of an independent panel of experts commissioned earlier in 2010 to look at the future challenges facing public sector budgets in Scotland. The published findings are commonly referred to as the Beveridge Report. It points out that the Scottish Government is facing six years of contraction from 2010/11 onwards. The report indicated that it could take 16 years for budgets to return to 2009/10 levels in real terms.

82. Until recently investment in the NHS in Scotland increased by well above inflation with funding uplifts reaching six per cent. This period of growth has now ended. The 2010/11 budget, for example, showed a real term funding increase of less than one per cent or £96 million. Future uplifts are likely to be under even greater pressure.

83. A sound system of financial management is a key aspect of best value. NHS boards' performance is measured against three financial targets: a Revenue Resource Limit (RRL); a Capital Resource Limit (CRL); and a cash requirement. All NHS bodies in Scotland achieved their financial targets in 2009/10. However, this is a period of 'calm before the storm' and NHS boards will be required to deliver significant recurring cost savings in order to maintain financial balance. Robust and deliverable savings plans will be crucial to NHS boards in balancing their books and releasing cost efficiencies for investment in services.

84. The Scottish Government decides the level of funding provided to NHS boards and they, in turn, are required to live 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 and are not yet apparent.

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

- National policy decisions, for example in relation to charges for prescriptions 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. Pay modernisation and associated pension costs have added significantly to the total NHS pay bill. For example, in the period 2003/04 to 2008/09 the cost of NHS salaries (excluding those associated with independent contractors such as GPs, dentists, opticians and pharmacists) rose from just under £3 billion to £5 billion. While pay costs may remain fairly static over the next couple of years, due to tighter central control of pay awards, the big challenge for NHS boards is how these costs can be managed overall.
- Between 1996/97 and 2008/09, drugs prescribing costs more than doubled in cash terms to £1.1 billion. Rising drugs costs will continue to remain a significant source of pressure particularly with the introduction and expansion in prescribing of new drugs approved by the Scottish Medicines Consortium.
- The current Efficiency Programme aims to reduce waste and bureaucracy and deliver a two per cent efficiency saving across the public sector. This target may only be achieved by cash releasing gains. Two per cent efficiency savings are unlikely to be sufficient beyond 2011 to bridge the gap between spending and the smaller budgets available.
- The increase in the VAT rate from 17.5 per cent to 20 per cent (effective from 1 January 2011) will add to the cost pressures facing the NHS in Scotland. The Cabinet Secretary in response to a parliamentary question indicated that this increase will add an additional £26.5 million of expenditure to the cost of the NHS in Scotland.
- Around a third of the NHS estate will require major upgrading in the medium-term. However, the capital allocations available to NHS boards are likely to be reduced significantly with funding prioritised in favour of a very few nationally significant projects, eg the new hospitals at the Southern General site in Glasgow. In October 2010, the Treasury estimated that, by 2014/15, the overall Scottish Capital Departmental Expenditure Limits would decline by 38.4

per cent in real terms when compared with a 2010/11 baseline. This will leave many NHS boards bidding for a share of a much reduced capital budget in future.

- The PPP/PFI route to deliver capital investment is not currently in active use and 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. The hub initiative led by the Scottish Futures Trust on behalf of the Scottish Government aims to deliver new community infrastructure projects expected to be valued at more than £1 billion over the next ten years. With the initiative at a very early stage, the first two pilot areas have been established, 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 2009/10, 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 NHSS Shared Support Services (SSS) Programme was relaunched during 2007/08 as a two tier initiative comprising:
    - a Foundation level, with all boards migrating to the same version of the Cedar eFinancials finance system during 2008 and achieving a minimum standard of business processes
    - pathfinder initiatives where selected boards or consortia test new systems functionality and associated business processes, before roll out to other 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 SGHD continues to take a measured approach to implementing NRAC recommendations to avoid creating financial turbulence within the NHS in Scotland.
- From 1 August 2009, the European Working Time Directive (EWTD) limits the number of hours doctors in training are permitted to work to 48 hours a week on average. Health boards will need to monitor the compliance with these regulations and manage the impact on costs of using additional locum cover.

Links to other work

86. Audit Scotland's *Overview of the NHS in Scotland's performance 2008/09 (December 2009)* comments on various aspects of performance including achievement of nationally determined service

targets and financial performance. It also considers the significant financial pressures facing the NHS in Scotland and the challenges posed by deep seated health-related problems. The financial position of boards and financial management of the NHS in Scotland will be updated in the forthcoming *Financial overview of the NHS in Scotland.* This report will focus on the financial performance of the NHS in 2009/10 and the challenges facing it moving forward.

87. Audit Scotland also published a report on *Scotland's public finances – preparing for the future* in November 2009. This contained a number of key messages for the public sector including NHS bodies. Some of these messages are summarised below:

    - The Scottish Government and the wider public sector need to work together to develop better activity, cost and performance information. This information is needed to enable informed choices to be made between competing priorities, and to encourage greater efficiency and productivity.
    - The Scottish public sector faces significant challenges in balancing its budget while also delivering on its commitments.
    - Two per cent efficiency savings will not be sufficient beyond 2011 to bridge the gap between public spending and the smaller budget available.
    - Changes in Scotland's population and rising unemployment rates will increase the demand or public services. In the NHS, for example, a growing elderly population will lead to further pressure on the acute and primary care sectors. Older people already account for 40.5 per cent of all emergency admissions to hospital.

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

    - *Review of orthopaedic services* (March 2010) highlighted that the NHS spent £373 million on orthopaedic services in 2008/09 and savings could be made by more efficient purchasing of surgical implants.
    - *Managing NHS waiting lists* (March 2010) reported that new arrangements – '*New Ways'* – have stopped people remaining on waiting lists indefinitely. The report also highlighted the problem that the percentage of patients who do not attend outpatient appointments has not reduced and in a three-month period to September 2009 this was estimated to have cost the NHS in Scotland some £5 million.

Key risks

89. 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 SGHD.
- 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, eg increase in the rate of VAT. 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.
- While no board will have funding reduced as a consequence of the NRAC review, overall funding uplifts will be less for some boards than would have been the case under Arbuthnott.

Savings plans

- 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
    - savings plans focus on recurring sources, are transparent and, where appropriate, include specific actions required to meet Efficient Government targets

- it is making progress in achieving its planned savings.

Capital programme

- Capital funding is insufficient to deliver NHS boards' capital programmes resulting in projects being delayed or cancelled. Capital receipts are unlikely to deliver the significant returns to bridge this funding gap. 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.

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

90. The current delivery and performance management arrangements for the NHS were introduced in 2006 by the then Scottish Executive Health Department. These are based on Local Delivery Plans (LDP), which are structured around a hierarchy of four key ministerial objectives: health improvement, efficiency, access, and treatment (HEAT) and a range of supporting measures.

91. 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 SGHD and form the basis for performance monitoring.

92. 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 SGHD 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.

93. Boards are expected to monitor and report progress against other key targets and initiatives, including Efficient Government and pay modernisation.[3] The latter requires boards to submit benefits delivery plans and progress reports to the SGHD to demonstrate how they are using the new staff contracts to deliver benefits. Quality outcomes measures to support and monitor progress against the Quality Strategy are due to be published shortly.

94. The Scottish Government is continuing to develop its approach to performance management based on a National Performance Framework and outcome agreements. The National Performance Framework is based on the outcome-based 'Virginia-style' model of performance measurement and reporting. In support of this, the Scottish Government has developed a new 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. There is an expectation that all public sector bodies, including the NHS, 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

[2] This is only available on NHSNet, so there is no reference in the PRF.
[3] *Delivering the benefits of pay modernisation in NHSScotland, HDL (2005)28,* Scottish Executive, 1 July 2005.

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.

95. The Scottish Government's Improvement Support Team is working with NHS boards to implement an efficiency and productivity programme. This includes the use of LEAN methodologies to improve their performance (a structured approach to identifying and delivering improvements). Most territorial NHS boards have now begun implementing full LEAN programmes. A number of benchmarking tools have been developed for NHS boards including: a Whole System Balanced Scorecard with a range of 80 indicators (currently being revised); Better Quality Better Value indicators provides analysis on variation in performance among NHS boards, hospitals and specialties; British Association of Day Surgery (BADS) Information System provides analysis on day case rates by procedure; and a National Theatres Implementation group has been overseeing a theatre benchmarking project.

96. 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 (formerly known as the Carbon Reduction Commitment) came into force in April 2010 and will affect 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. This will affect organisations whose annual energy consumption is more than 6,000 megawatt hours.

Links to other work

97. As part of its programme of work on the audit of Best Value, Audit Scotland has developed a toolkit on performance management. This will be applied in a future year.

98. Audit Scotland published *Improving energy efficiency* in December 2008 and this study included NHS bodies. A follow-up study is due to be published in December 2010.

99. Audit Scotland published its report on *Managing NHS waiting lists* in March 2010. The report noted that the New Ways approach has stopped people remaining on waiting lists indefinitely. It introduced significant changes to the way patient waits are managed, and the NHS has done well to implement the new arrangements.

Key risks

100. 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 SGHD and monitored by the Directorate of Delivery. 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 2010.

Capacity to deliver

Background

101. NHSS 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 continuing reduction in prescription charges, and the anticipated period of severe financial pressures brought on by the post-2008 economic downturn and flagged in the national Comprehensive Spending Review of October 2010. This pattern of simultaneous pressures results in a particular challenge for boards – that of ensuring that they have the organisational capacity to address a whole range of developments, all of which are required for the successful delivery of NHSS's core objectives.

102. As the economic downturn continues to have its effect there could be implications for NHS staffing levels, although, at the time of writing, a policy of no compulsory redundancies continues to apply within NHSScotland.

103. *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.

104. 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.

105. 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 NHSS 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

- there remains a risk of a significant further outbreak of H1N1 influenza during the 2010/11 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 SGHD'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.

106. The *eHealth Strategy 2008-2011*, published in June 2008, describes a number of significant information technology (IT) procurements and developments that will be required to support service redesign. Boards need to ensure that:

- eHealth initiatives are fully integrated with clinical and service redesign programmes
- arrangements are in place to guarantee that business continuity and contingency plans are developed, tested and reviewed
- staff fully understand their duty to keep data confidential
- they are able to demonstrate that they fully comply with all information assurance legislation.

107. 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

108. Audit Scotland published studies on *Managing NHS waiting lists* in March 2010, *Using locum doctors in hospitals* in June 2010, *Emergency departments* in August 2010 and *The role of boards* in September 2010. All of these have implications for managing NHS Service delivery, particularly in the context of stretched resources.

109. 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

110. 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 an annual workforce plan and contribute to regional workforce plans as required
    - 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 SGHD 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.
- There remains a risk of a significant further outbreak of H1N1 influenza during the 2010/11 period. The board should be able to demonstrate that it has robust business continuity plans in place to deal with the staffing and service implications of such a development.

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.

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.
- 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 SGHD. 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 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 SGHD 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.
NHS Quality Improvement Scotland (NHS QIS)	NHS QIS 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. Will become part of NHS Health Improvement Scotland from April 2011.
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 Directorates (SGHD)	The SGHD (previously known as the SEHD) is responsible both for the NHS in Scotland and the development and implementation of health and community care policy. The SGHD 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 (SPSA)	The programme was set up by the Scottish Patient Safety Alliance in 2007. NHS QIS 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.
Virginia Model	A strategic planning and communications, outcomes-based performance model, used in the State of Virginia, USA.

Priorities and Risks Framework

A national planning tool for 2010/11 NHSScotland audits

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Audit Scotland, 110 George Street, Edinburgh EH2 4LH
T: 0845 146 1010 E: info@audit-scotland.gov.uk
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