Priorities and Risks Framework

A national planning tool for 2006/07 NHSScotland audits

September 2006

Auditor General for Scotland

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- Scottish Water
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Introduction

Audit approach

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

2. 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, sufficient to identify and assess the risks of material misstatement. Our understanding of the business will be informed by the PRF.

What is the role of the PRF?

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

4. Although the PRF presents a national view, it will inform the planning of local 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?

5. Sector specific PRFs are developed each year by multi-disciplinary groups which comprise representatives from Audit Scotland and private firms, clients and other Sector representatives. Workshops are held to identify the key issues facing the sector in the coming year and select the priorities for coverage.

How will auditors use the PRF?

6. The PRF should form 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. Audit activity can then be targeted to areas where local action is insufficient to address key risks or where

there has been slippage on action to meet key national priorities. This can be through development of local audit studies which can provide evidence of achievement of value for money or best value.

7. 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.

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

8. An appropriate recording mechanism for the results of the PRF is essential in ensuring local audit plans are supported by appropriate evidence. Local 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. There is no requirement to report the PRF risk assessment to clients as a specific output. The risks identified and related audit work will be reported as they are incorporated into 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.

Service Sustainability

Background

9. In *Delivering for Health*, published by the Scottish Executive in 2005, the Minister for Health and Community Care, states that 'at a national level, we will continue to support greater integration within the health service and other social services. We will seek improvements in the quality of health care and in productivity too. We want services delivered as locally as possible, when that can be done safely and sustainably, but with prompt access to specialised services when necessary'.

10. *Partnership for Care: Scotland's Health White Paper* and *Delivering for Health* detail the following drivers of service redesign:
    - an increasing older population;
    - a reduced working population;
    - the emergence of long term conditions as the main challenge facing the health service;
    - changing expectation from patients for more personalised care; and
    - the affordability of current services - Audit Scotland's NHS overview reports continue to highlight that a number of NHS boards are failing to operate within their allocated budgets and that increasing funding gaps may have an adverse impact on the delivery of sustainable services.

Why is it important?

11. NHS boards have limited resources to meet the needs of current and future patient populations and the majority of additional funding will continue to be absorbed by significant recurring cost pressures, including pay modernisation and increased drugs costs. The Scottish Executive Health Department (SEHD) believes that service redesign will be delivered through pay modernisation but the Scottish Parliament's Audit Committee reported in 2005, 'the cost of funding pay modernisation makes it more difficult for boards to fund other new services' and that the Committee was 'concerned that the benefits to patients of pay modernisation remain unclear'. If, after pay modernisation is bedded in, further redesign is necessary, there will be very little additional funding left for this.

12. Within *Delivering for Health*, the Health Minister has identified a number of key steps to be delivered in 2007:
    - new and more innovative ways of working;
    - better workforce planning – having the right skills in the right place;
    - more investment in capacity where it matters;

- more effective use of the independent sector;
- innovative Community Health Partnerships (CHPs); and
- more strategic and effective use of information and communication technology.

13. 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, including 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);
    - affordability and the ability to demonstrate best value and benefit realisation;
    - implementation of robust systems to obtain information on current and future service provision; including consideration of patient needs and expectations, the lack of which is consistently reported by auditors and the Scottish Parliamentary Audit Committee; and
    - ensuring that modernised and redesigned services are safe and effective and improve the quality of care and treatment of patients.

What are the current operational risks and risk areas?

14. These include:

    - Without service redesign the board cannot continue to meet the demands of its patient population, including improved access, increased activity and an improvement in the patient's experience as outlined in *Delivering for Health*.
    - Insufficient planning procedures do not allow the board to accurately determine current service delivery and performance, impacting on its ability to plan future service delivery.
    - The lack of an integrated planning process results in inaccurate costing of service delivery and insufficient consideration of the link between service delivery, financial constraints and the requirement to meet national priorities and targets.
    - Internal and external stakeholders, including CHPs, operating divisions, patients, local authorities, regional planning groups, SEHD and Scottish Ministers, are not fully involved in service redesign, which may result in a lack of financial and operational commitment.
    - Poor programme and project management results in late or inefficient and ineffective project delivery for key redesign projects.
    - NHS boards are constrained in their ability to redesign services due to inflexibility imposed by PPP/PFI contracts.

- Inadequate procedures exist to identify and dispose of redundant assets and manage staff redeployment resulting from continued service redesign.
- Priorities outlined in the local delivery plan are sacrificed when financial pressures arise.

What are the key issues for local auditors?

15. The key issues for local auditors include:

- The board's vision of where the organisation will be in the next 3 – 5 years and beyond is informed by an understanding of internal and external stakeholders' needs and addresses national priorities and policies, including the requirements of *Delivering for Health*.
- The board takes an integrated approach to planning, ensuring that all plans published are financially and operationally achievable and based on robust current and estimated future service and activity levels. Costs are established from completion of a comprehensive baseline exercise.
- The board has undertaken a baseline assessment to establish the level and types of service currently being delivered and identify if there are any gaps in service or capacity.
- The board has 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.
- Where a financial recovery plan is needed, it considers future service delivery and appropriately prioritises the areas that are subject to financial constraint. Financial recovery plans (short and medium term) fully consider longer term service reconfiguration and redesign.
- The board has established robust project management systems to ensure relevant processes are followed, including option appraisal and consideration of PPP/PFI, and implemented a mechanism for reviewing the effectiveness of these processes.
- The board can demonstrate that it is engaging with stakeholders to gain support and obtain their involvement in service redesign.
- The board has systems in place to provide assurances that redesigned services are safe and are improving the quality of care for patients.

Financial Management

Background

16. Investment in NHSiS is increasing each year, from £8 billion in 2005/06, to £10 billion by 2007/08, but this level of increase is not sustainable in the long term.

17. NHS boards' performance is measured against three financial targets: a Revenue Resource Limit (RRL); a Capital Resource Limit (CRL); and a cash requirement. A number of NHS boards continue to report annual and cumulative deficits and others are forecasting financial difficulties in future years, however, NHSiS as a whole continues to report an overall cumulative surplus. The SEHD recovers in-year deficits by reducing the following year's funding allocation, impacting on available funding in future years.

18. Audit Scotland has highlighted in recent overview reports that financial management arrangements, including financial planning, need to be sound and that sufficiently skilled staff and appropriate systems should be in place. Auditors are increasingly raising concerns about financial planning – both short and long term – identifying underlying funding gaps in NHS boards' financial plans and that financial plans are not always linked to other planning activities.

19. The Scottish Executive's Efficient Government initiative is a five year programme to reduce waste, bureaucracy and duplication in the public sector. A total cash releasing savings target of £367 million has been set, including efficiency savings of 1% per annum on a cumulative basis, for NHSiS. In addition, a target of £173 million for time releasing savings has also been set, which will increase the level of service from the available resources. Savings are to be achieved in a number of key areas, including procurement, prescribing, consultant productivity and sickness absence.

20. The duty of accountable officers to ensure the existence of arrangements to achieve best value was established in 2002. The principles require an organisation to demonstrate a sound system of financial management and control, evidence that the financial consequences of decisions are assessed before commitments are entered into and establish a sound financial position.

21. A number of factors are influencing NHS boards' ability to plan and manage their finances effectively to meet financial targets, including:

    - redesigning services to meet national and local priorities and targets, including managing the impact of *Delivering for Health*;
    - the increasing impact of local and national savings targets;
    - the loss of the facility to make capital to revenue transfers;

- staffing issues arising from pay modernisation and the move towards implementation of shared support services;
- reliance on non-recurring funding and ring-fenced monies to fund recurring expenditure;
- the size and age of the NHSiS estate, including the ongoing financial impact and conditions of the use of the PPP/PFI route to deliver improved facilities; and
- poor cost information being readily available locally and at a national level (this factor may become more significant following the introduction of national tariffs.)

Why is it important?

22. NHSiS is facing challenges which will put added pressure on financial management including pay modernisation, the Efficient Government initiative, the need to modernise services and the duty to provide best value. These challenges will require a better understanding of risk, improved financial forecasting and modelling, integrated finance and activity data, increased use of option appraisals for all new developments, and the requirement to demonstrate benefits realised from current and additional funding.

23. NHS boards must meet the needs of current and future patient populations and maintain robust financial management systems to support changes in service delivery.

24. Board members, including non-executive directors, have key roles in overseeing financial management activities, including the achievement of recurring financial balance, and ensuring that spending decisions are sound and will secure service improvement.

25. The objective of the Efficient Government initiative is to deliver continuous service improvements which are real and measurable. This will mean planning for efficiency gains each year while continuing to improve performance and making best use of resources in the long term.

What are the current operational risks and risk areas?

26. These include:
    - The financial planning process focuses on annual budgets and does not consider the long term planning strategy, including the impact of local and national shared services.
    - 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.
    - The board's financial model is inflexible and is not subjected to sensitivity analysis to deal with variations from the financial plan or changes in guidance and accounting standards.

- Financial plans, including recovery plans, are not fully 'owned' by key managers across the organisation, including senior clinicians.
- Non-recurring funding continues to be used to support financial balance and recurring operational activities and mask underlying recurring deficits. A number of Boards are not in recurring balance and this may become an increasing risk should the growth of health funding reduce.
- Staffing issues and possible discontinuities arising from pay modernisation and the move towards implementation of shared support services impact on the standard of delivery of financial services.
- Savings from shared support services may not be fully realised and the cost of change may be greater than forecast.
- Financial and service planning processes are not formally integrated and do not demonstrate that funding has been allocated to key service areas while considering the ongoing revenue implications of such areas as PPP/PFI, including any planned re-financing. The appropriateness of the PPP/PFI route, taking account of the need for future flexibility of service, is not fully considered.
- The accountability arrangements and financial processes are not in place 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.
- Single system financial ledger systems have not yet been implemented resulting in inadequate financial information, impacting on management's ability to prepare regular, transparent and timely financial reports to the board.
- 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.
- Savings plans are unrealistic and include savings from non-recurring sources and cost avoidance, and release savings to meet in-year cost pressures but do not reduce underlying recurring expenditure. Savings plans focus on service reduction and do not provide genuine efficiency savings as specified in the Efficient Government initiative.

What are the key issues for local auditors?

27. These include:

- Appropriate financial planning methods result in robust short and long term financial plans. Timescales of savings targets and financial recovery plans, and how these will be reported, are agreed with the SEHD.

- Financial and service planning are well integrated and serve to ensure that service funding matches the real pattern of healthcare need and is not distorted by shorter terms decisions on the availability of savings.
- The board can demonstrate its commitment to reducing reliance on non-recurring funding, for example fixed asset disposals, and focuses efforts on internal financial management.
- Financial plans are based on robust base cost and activity data and the budget monitoring system includes 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 and its committees receive transparent and 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 division(s), CHPs and existing, new and amended PPP/PFI arrangements.
- Board members have sufficient support and training to effectively scrutinise financial plans and monitoring.
- Financial risks are appropriately included in the risk register and responsibility for risk management and reporting on these areas is formally allocated to individual directors.
- The board has identified specific output and outcome measures to demonstrate continuous improvements in patient care from additional investment.
- Savings plans focus on recurrent savings, are transparent, including specific actions required to meet Efficient Government initiative targets, and seek to rationalise baseline expenditure.
- A robust and integrated single financial system is established to allow management to prepare effective and transparent budgets and subsequent reports on the financial impact of shared services, joint budgets and regional planning.

Governance

Background

28. 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’. By having good governance arrangements in place the Standard states that this should in effect lead to ‘good management, good performance, good stewardship of public money, good public engagement and, ultimately, good outcomes’.

29. The key principles of good governance, as outlined in the Standard are:

    - focusing on the organisation’s purpose and on outcomes for citizens and service users;
    - performing effectively in clearly defined functions and roles;
    - promoting values for the whole organisation and demonstrating the values of good governance through behaviour;
    - taking informed, transparent decisions and managing risk;
    - developing the capacity and capability of the governing body to be effective; and
    - engaging stakeholders and making accountability real.

30. These core principles are the basis of a universal standard of good governance applicable to all organisations and partnerships which work for the public, using public money.

31. The key components of governance within which NHS boards are required to operate are:

    - financial governance;
    - staff governance; and
    - clinical governance.

32. Financial governance 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.

33. The concept of clinical governance was formally established in the white paper *Designed to Care* and was defined as 'corporate accountability for clinical performance' to ensure that quality of care was given the same prominence as other key drivers such as finance and staffing. Clinical governance is the system for making sure that healthcare is safe and effective and that patients and the public are involved. NHS Quality Improvement Scotland (NHS QIS) is charged with improving the quality and treatment of care delivered by NHSiS. The *Standards for Clinical Governance and Risk Management* were published in October 2005 and a programme of reviews is in place to assess all boards against these standards in 2006-7.

34. Staff governance refers to a system of corporate accountability for the fair and effective management of all staff. NHSiS's staff governance standards set out the minimum level of performance expected of NHS boards. NHS boards' staff governance committees are responsible for creating the right culture for people management and monitoring performance against the standards. Staff governance issues are further addressed in the people management section.

Why is it important?

35. NHS boards need to demonstrate that they have established and maintain an effective continuous framework for identifying, evaluating and managing business risks. A strong governance framework is even more important in a culture of continuous improvement and in an environment of rapid and major change, for example the ongoing development of CHPs, shared support services, regional planning and the Efficient Government initiative. 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 made in the annual Statement on Internal Control.

36. The Turnbull report *Internal Control: Guidance for Directors on the Combined Code* states that a sound system of internal control depends on a thorough and regular evaluation of the risks faced by the body. NHS boards must be able to identify clearly the key corporate risks facing the organisation and ensure that effective controls and measures are put in place to minimise and address these risks.

37. Robust clinical governance structures will be essential to demonstrate NHS boards' effectiveness in meeting patients' needs and patients' safety. Clinical governance provides assurance to patients, clinical staff and managers that:

- the quality of clinical care drives decisions making about the provision, organisation and management of services;
- planning and delivering services take full account of the perspective of patients;
- the care delivered by boards and their operating divisions meets relevant standards; and
- unacceptable clinical practice will be detected and addressed.

38. *Delivering for Health* highlights the need for the NHS to work with partners in local authorities and community planning in delivering services. An increasing number of services will be delivered through the new CHPs and boards are expected to work with each other through regional planning groups. Effective governance arrangements are therefore of key importance if joint working arrangements are to operate effectively. Boards need to ensure that public resources are used appropriately and effectively across joint working arrangements.

What are the current operational risks and risk areas?

39. These include:

- The governance framework implemented locally does not contribute to an effective, efficient and economic local health service. In extreme cases ministerial intervention is required to ensure proper accountability, openness and integrity.
- Non-executive board members lack the capacity to fully or effectively carry out their governance role. Board members are reactive to strategy and direction provided by executives. They are therefore unable to challenge effectively and hold management accountable to the public and other stakeholders.
- The board is not provided with sufficient information on the impact decisions will have on resources and performance to allow members to properly discharge their governance responsibilities.
- Failure to implement a robust risk and control framework results in a breakdown in core business system processes and controls and ultimately a failure to maintain service delivery.
- Effective clinical governance and risk management arrangements are not in place to support the delivery of safe, effective, patient-focused care and services.
- Delegated authority to operating divisions, CHPs and Joint Future partnerships is not supported by clear, formal schemes of accountability and delegation.
- Management capacity is insufficient to maintain or improve the performance of the local health system in the face of competing service developments and demands.
- Public involvement and stakeholder and staff consultation is not integrated within the policy and decision-making processes of the board.
- Committees' roles, membership and remits do not comply with current guidance, for example the audit committee handbook.

What are the key issues for local auditors?

40. These include:

- A corporate governance framework has been developed with efficient committee structures in place to support the board. Standards of reporting and information required to support effective governance and accountability have been agreed. Lines of communication have been clearly defined throughout the single structure and clear accountability exists throughout the organisation.
- The board has the required strategic plans in place to demonstrate how service modernisation and redesign can deliver a modernised health care service to the local population. These are co-ordinated in focus and fully supported by a financial strategy that includes detailed and realistic plans linked to available resources, to achieve its overall objectives.
- Training plans for senior managers and board members have been developed to ensure that operational and strategic managers have the capacity and skills to deliver improved services. Observation at committees and board meetings provides evidence that members effectively challenge and hold officers to account. There is evidence that board members participate in an annual review of their performance conducted by the board chairperson.
- Sound systems of performance and risk management are in place to support good governance and to monitor progress against the targets set by SEHD.
- The board has put in place clear plans to meet the requirements identified from their NHS QIS peer review and these plans will be regularly monitored to ensure that clear improvements are made prior to the next annual review by the Minister.
- Relationships and dialogue with partner organisations and other key stakeholders, including public and patient representatives, have been maintained and developed in the new structure. Board plans and actions are informed by an understanding of stakeholder needs.
- Clear governance arrangements exist and clear lines of accountability are in place for all areas of joint working and in areas where regional working exists.

Performance Management

Background

41. Historically there has been a perception that performance assessment arrangements for NHSiS may not address priority areas and give more weight to financial performance and efficiency, rather than quality of patient care and equity of access to services.

42. The Chief Executive of NHSScotland announced new delivery and performance arrangements in December 2005. These arrangements included the introduction of local delivery plans (LDPs), the creation of a Delivery Group within the SEHD and agreement of a core set of key objectives, targets and measures. In 2006/07, LDPs were introduced as one of the main strands of the SEHD's new performance management arrangements. NHS boards are required to produce LDPs which state their planned levels of performance against a core set of 28 key targets (HEAT targets) monitored through 32 measures. NHS boards agree these levels with the SEHD and these form the basis for performance monitoring. The LDPs should also detail how the boards will achieve these targets using available resources.

43. LDPs replace local health plans and the Performance Assessment Framework (PAF). The SEHD plans to carry out regular monthly monitoring of board performance against the planned levels of performance agreed in the LDP, from summer 2006.

44. *HDL (2005)28* required NHS boards to take local actions to focus on delivering benefits through pay modernisation. It also requires boards to submit benefits delivery plans and progress reports to the SEHD to demonstrate how they are using the new staff contracts to deliver benefits.

45. A Delivery Group was established within the SEHD in early 2006, bringing together the National Waiting Times Unit, the Centre for Change and Innovation, the Performance Management Division and others. It is responsible for agreeing the annual LDPs with NHS boards and monitoring performance, particularly through the LDPs and benefits delivery plans. It will produce benchmarking reports to support this process. The Delivery Group has the power to intervene at boards if necessary.

46. From 2005, annual reviews have been held in public between the SEHD and each health board. The PAF, performance against waiting times targets, achievement of plans and other independent assessments of performance form the basis of these reviews. From summer 2007, annual reviews will relate to the performance measures in the LDPs. The purpose of the reviews is to reach a shared view between the board and the SEHD about the board's level of performance. An overall assessment of performance is prepared by the SEHD and the board and shared with the public. An action plan is agreed listing key areas to be addressed by the board.

47. As part of the Efficient Government initiative, the Scottish Executive supported pilots of the Citistat performance management tool in two NHS boards (Tayside and Ayrshire and Arran) and two local authorities. The results from the evaluation of the pilots were reported in July 2006. The findings include: this system improves the quality of information and makes it easier to understand and scrutinise performance information; applying the Citistat tool can improve performance management in public sector bodies in Scotland. The Health Minister commented that extended use of Citistat could improve performance. NHS boards should consider whether this tool could be applied locally to improve performance management.

Why is it important?

48. Through the LDPs, NHS boards are expected to agree performance levels and to monitor progress against each of the core targets and indicators. The Delivery Group and other departments of the Scottish Executive will also be reviewing further performance management measures as appropriate.

49. It is important that whatever performance management systems are used they provide the information required to effectively manage and monitor the local health system. The information in the LDPs and updates should come from the local performance management system.

50. Significant additional money has been committed to supporting new contracts for NHS staff and NHS boards need to demonstrate whether this is resulting in appropriate, measurable benefits. Boards are required to report regularly to SEHD on benefits realised from pay modernisation.

51. The Efficient Government initiative requires NHS boards to achieve cash releasing and time releasing savings across a number of work streams. NHS boards need to be able to identify and achieve these savings.

52. A Scottish Public Finance Manual update in May 2006 outlines the duty of best value placed on public bodies. This guidance from the Scottish Executive is part of the process of embedding the principles of best value across the public sector. These principles are intended to promote continuous improvement in the public bodies' performance. Effective performance management systems are a requirement to achieve and demonstrate best value.

What are the current operational risks and risk areas?

53. These include

- Performance management and reporting are not given sufficient priority at an appropriate level within board committee structures and performance against core targets is not routinely reported to the board or corrective action taken.

- Systems are not in place to use LDPs and core targets as part of performance management and/or the board is not able to meet performance levels agreed in the LDP or reporting deadlines required for the LDP.
- Data is inconsistent and inaccurate.
- National and local targets for community care are not linked to local improvement targets required under the Joint Performance Information Assessment Framework (JPIAF) introduced as part of the Joint Future agenda. This results in the risk of duplication and / or inconsistencies in performance reporting.
- Performance management systems within NHS boards operate in isolation and are not appropriately linked to those established by partnership organisations within and outwith NHSiS.
- Performance management information relating to the CHPs is not well established or linked with other performance information.
- Trying to achieve national targets and priorities takes priority over delivering sustainable services that meet the needs of the local population.
- Variations and amendments to the national definitions of key targets, for example waiting times and delayed discharges, result in inconsistent and incomparable data and have an adverse impact on target achievement.
- Local systems do not monitor whether time-releasing and cash releasing savings are being achieved in line with Efficient Government targets.

What are the key issues for local auditors?

54. These include:

- Performance management is an integral part of the board's strategic, operational, financial and patient focused planning process.
- The board demonstrates consideration of and compliance with relevant principles of patient focus and public involvement within its performance management framework.
- The board formally allocates responsibility for performance management to a specific committee / executive director(s) for which a specific remit/job description is prepared.
- Local performance targets have been identified in conjunction with local partners, operating divisions and the public.
- There are robust systems for collecting and collating LDPs, core target and other national target information and to identify and monitor progress in achieving time-releasing savings.

- Performance management systems within CHPs and joint future partnerships are robust and effectively monitor performance.
- There are systems to allow formal comparison of inputs against outputs/outcomes and performance information feeds into a local performance management framework which is able to address quickly poor performance and failure to achieve local or national priorities.
- Performance, financial management and reporting systems are linked and can respond to the requirement to report accurately on Efficient Government and other targets, and are regularly considered at a strategic level. Innovative approaches such as 'Citistat' are actively considered.
- Performance management leads to continuous improvement in service delivery, for example the board has a robust process for taking action on NHS QIS standards and following up NHS QIS reviews.
- The board is aware of the impact of other organisations, both within and outwith NHSiS, on its performance.

People Management

Background

55. People management interacts with service planning and re-design and considers all staff groups in an integrated way. *Delivering for Health* promotes different models of care, new ways of working and new and extended roles for staff. The key priorities within *Delivering for Health* and *Partnership for Care* are the development of community based and seamless care, with strengthened primary care teams to develop integrated care plans for patients. NHSiS staff are key to delivering these improvements through redesigned services, new ways of working and extended roles.

56. Staff need training to adapt to new ways of working. Plans for training also need to reflect national initiatives such as the Knowledge and Skills Framework (KSF), a component of Agenda for Change intended to encourage continuous professional development, and Modernising Medical Careers (MMC), the new training arrangements for junior doctors.

57. SEHD has set up a project to oversee the planning and implementation of the Scottish Workforce Information Standard System (SWISS). Information Services Division (ISD) published limited data from SWISS in June 2006 (relating to period to January 2006) and some data was also available to boards prior to that. Further development of SWISS is planned over the next few years but the availability and usefulness of reports from SWISS depends on NHS boards registering to be able to access the information, and on them keeping the national database up-to-date.

58. Recruitment and retention of staff are problems in a number of NHS boards and in a number of specialties. The National Health Workforce Planning Framework, published in August 2005, established a framework at national, regional and NHS board level for workforce planning. The actions outlined were reinforced through the HDL issued in November 2005 and through *Delivering for Health*. Progress on these actions will be monitored and reported on in subsequent workforce plans:

    - NHS boards and regional workforce planners should work together to produce regional workforce plans by January 2006, followed by annual plans each September;
    - NHS boards should produce board plans by April 2006 and each April after that; and
    - The SEHD will produce a National Workforce Plan in December 2006 and each December after that, informed by the regional and board plans.

59. NHS boards are required to have arrangements in place to ensure compliance with NHS staff governance standards. If a board fails to implement these arrangements, Scottish Ministers have the authority to implement their general direction making powers to require boards to comply with these requirements.

60. With the development of CHPs, staff employed by NHS boards and staff employed by local authorities are working together as part of joint teams. These teams can include staff with similar roles but different employers and different terms and conditions.

61. The Scottish Executive's policy on relocation of public bodies will impact on some special health boards, with implications for the services they deliver. The Executive has announced plans to relocate NHS QIS, NHS Education Scotland and NHS Health Scotland.

Why is it important?

62. *Partnership for Care* and *Delivering for Health* highlighted that in order to improve healthcare, NHSiS must support, value and empower staff who deliver care. This means giving healthcare teams support and incentives to design and deliver integrated services around the needs of their patients, while investing in staff and equipping them with the skills and facilities they need to do their job.

63. Significant amounts of additional money have gone into new contracts for NHS staff. *HDL(2005)28* on delivering the benefits of pay modernisation in NHSiS, outlined the approach to be taken by boards to manage and monitor the process to achieve and demonstrate benefits. Boards are required to submit benefits delivery plans and progress reports to the SEHD.

64. NHS boards need to identify, plan, budget for and provide staff training and development needs arising from the KSF and MMC, in addition to the needs arising from service redesign and changing roles. Also, boards are no longer permitted to use non-contract suppliers of agency staff and must put in place alternative arrangements.

65. The European working time directive has impacted on people management within NHSiS, most noticeably through the New Deal for Junior Doctors. This restricts the average working week for junior doctors to 56 hours but will progressively reduce this to 48 hours by 2009, and can affect service delivery in some departments. Compliance with the new deal is now over 99% across Scotland, although it is lower in some NHS boards.

66. The 2005/06 staff governance audits highlighted that although there has been some progress, NHS boards still had to implement many actions identified previously. Lack of workforce information was still an issue in a number of boards.

67. As part of the Efficient Government agenda, NHSiS is progressing a shared support services project which will affect all staff currently working in finance, procurement and payroll. Current estimates are that across Scotland approximately 600 staff will be re-deployed as a result of the project, with further staff moving from their current NHS board to work within the central "hub" framework. Re-deployment

will be managed locally. A decision on the site of the two planned “hubs” was due in December 2005, but is now not expected until the end of 2006 at the earliest.

68. Developments such as job matching through Agenda for Change, extended roles, for example nurses taking on roles previously carried out by doctors, redesigned services and staff from different employers working on joint teams, lead to concerns about possible inequity in treatment and risks of staff raising equal pay claims (potentially backdated) against NHS boards. Some boards have already reflected equal pay claims as a contingent liability within their annual accounts.

What are the current operational risks and risk areas?

69. These include:

- 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.
- There has not been a review of business processes and allocation of resources where necessary to ensure the SWISS database is kept up to date. Contingency plans are not in place to manage the risks of SWISS not delivering the information expected, or of it not delivering to expected timescales.
- Workforce development 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.
- Training plans and budgets do not take full account of KSF and MMC requirements and other changes in roles and delivery of services.
- Personal development planning is not fully integrated into quality and performance improvements.
- Management capacity is insufficient to meet the requirements of planning, 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.
- Insufficient funding is available to fully implement the pay modernisation agenda and the extra funding for pay modernisation does not deliver value for money. The board does not have procedures in place to assess and demonstrate how it is delivering the benefits of pay modernisation.
- Uncertainty about the impact of the shared services review may have an adverse impact on staff morale and performance or leads to retention difficulties. Plans are not in place to deal with the loss of local knowledge that may arise with the loss of local services.

- The board does not have plans to manage the risks of equal pay claims.
- For boards directly affected by relocation, there are risks to the provision of services through difficulties recruiting and retaining staff and through failure to progress on future business developments in the period of change.

What are the key issues for local auditors?

70. These include:

- There is evidence of substantial efforts to improve the organisation's information capability to meet the requirements of staff governance and to ensure that the SWISS database is kept up to date. The information generated through SWISS is kept under review to ensure that it meets the board's information needs and contingency plans are in place to address any deficiencies.
- Workforce requirements to resource the NHS in the short, medium and longer term are being quantified, taking into account planned changes in service redesign, working practices, training, service delivery and resources. Pay modernisation is actively being used as one of the drivers for change, with value for money considerations being addressed as part of the process.
- The board develops annual workforce plans and contributes to regional workforce plans as required. It has arrangements in place to take forward the workforce plans. Workforce developments are integrated into local delivery plans. Re-skilling, re-location, recruitment and retention issues are considered in the board's planning processes, on a local and regional level, to address particularly difficult areas.
- Financial plans include up-to-date and accurate forecasting for Agenda for Change and other strands of pay modernisation and the board is actively managing the impact. The board has procedures in place to enable it to produce Pay Modernisation Benefits Delivery Plan progress reports to SEHD and to meet the requirements of *HDL(2005)28*.
- The board has identified training needs and budget requirements in relation to KSF, MMC and redesign of services.
- Planning has been undertaken to address the implications for staff of the Shared Support Services project.
- The self assessment tool is completed annually for the staff governance standard and the work is assessed and reported in accordance with *HDL(2004)39*. The board has processes in place to address any issues included in the action plan.
- The board continues to monitor doctors' hours in accordance with the New Deal and European Union Working Time Directive.

- The board no longer uses non-contract suppliers of agency staff and has put in place alternative arrangements.
- The board has identified the risk of possible equal pay claims, has taken steps to reduce this risk and has put in place plans to deal with such claims. The board has taken action to harmonise terms and conditions for staff working as part of joint teams but with different employers.

Partnership Working

Background

71. Partnership working in the NHS covers a numbers of areas, including partnership with:

    - staff groups;
    - local authorities;
    - voluntary sector;
    - private sector health care providers; and
    - regional planning between NHS boards.

72. The NHS routinely works in partnership with other organisations to deliver health services and meet its aims and objectives. The need to work collaboratively is enshrined in both the Partnership Agreement and in *Partnership for Care*, which states that improvements in the health of the people of Scotland cannot be achieved by SEHD or the NHS boards alone. The area boards throughout NHSiS depend on services provided by special health boards such as the Scottish Ambulance Service and NHS 24.

73. These themes were developed in *Delivering for Health*, which emphasises the need for the NHS to operate in an integrated fashion and adopt a partnership approach to achieve improvements in the quality of service and in the delivery of value for money. It further states that CHPs will be the main vehicle for improving services. The aim of CHPs is to make a real difference to improving the health of the population and to improve the patient's journey of care.

74. Most CHPs were effective from 1 April 2005 and a variety of CHP models are now in place throughout NHSiS dependent on the extent to which local areas had progressed the Joint Future agenda prior to the CHPs being established. In the main they provide a focus for integration between primary care and specialist services and with social care. To support this, the membership of CHP Committees must include a senior manager from the board, and representatives from across a number of front line organisations including local GPs, nurses, local authorities, dentists and community pharmacists etc. However, some boards are already recognising the need to amalgamate their existing CHPs resulting in further necessary changes to the newly established governance structures and committee memberships.

75. CHPs are viewed as the main NHS agent through which the Joint Future agenda is delivered in partnership with local authorities and the voluntary sector. It is therefore important that the Joint

Future Agenda and CHPs are progressed in tandem in local areas to ensure that they can deliver their objectives.

76. *Partnership for Care* also recognised that only through 'better planning and co-operation at a regional and national level' will it be possible for NHSiS to provide the full range of modern health services. The objectives and benefits of regional planning will ensure clinical sustainability of services and provide equitable access to services. This will involve better pathways of care or combined service provision which will support local services and help deliver local delivery plans and is key to delivering the Kerr report's vision of local service delivery supported by centres of excellence.

77. Partnership working between NHSiS and the private sector is a feature of the delivery of healthcare services in England, in the form of Independent Sector Treatment Centres (ISTCs). In Scotland private hospitals have been used by NHSiS in a bid to meet waiting times by individual health boards. NHS Tayside is however in the process of establishing an ISTC at Stracathro Hospital which will be operational in Autumn 2006 and there is an expectation from the SEHD that if this venture is successful then further centres will be created across Scotland.

Why is it important?

78. NHS boards need to be able to demonstrate that they are delivering effective services that meet the needs of patients and their carers. Working in partnership with other organisations will help the NHS fulfil the requirements of *Delivering for Health*. This notes that joint working will continue with local authorities, between NHS organisations, with third parties and also with the independent sector.

79. Regional planning is an example of partnership working within NHSiS and will help ensure clinical sustainability of services and provide equitable access to services. Regional planning groups should also ensure that they harness the support and potential of MCNs. This should result in better pathways of care or a combined service provision which will support local services and help deliver local delivery plans. The importance of regional planning groups, notwithstanding the statutory duty under *HDL(2004)46*, is highlighted in *Delivering for Health*.

80. The Joint Future agenda sets the direction for joint working which will underpin all community care services. It is a challenging agenda requiring major organisational, operational and financial changes, as well as cultural changes. The SEHD is keen for this agenda to move forward, and the introduction of CHPs reinforces the requirement for effective joint services. Recent Audit Scotland reports have highlighted that more action is needed to progress joint working between the NHS and councils. This issue was also raised in the Parliamentary Audit Committee's 2005 report on community care.

81. Scottish Ministers want to underpin nationally agreed outcomes with the development of local improvement targets (LITs) for health and community care. Partnerships are now required to develop

LITs which focus on four key national outcomes as part of their local joint performance management frameworks. The national outcomes are:

- supporting more people at home as an alternative to residential and nursing care through locally agreed joint service developments;
- assisting people to lead independent lives through reducing inappropriate hospital admissions, reducing time spent inappropriately in hospital, and enabling supported and faster discharges from hospital through service developments;
- ensuring people receive an improved quality of care through faster access to services and better quality services; and
- better involvement and support of carers.

82. Assessments of how local partnerships perform may inform the annual review process. Ministers also have power to intervene if partnerships between NHS boards and local authorities are not making sufficient progress. A Joint Improvement Team (JIT) has been set up to work with local partnerships to support improved outcomes for clients and their carers.

What are the current operational risks and risk areas?

83. These include:

- CHPs are not seen as a key driver to improve local health services, support service redesign or to facilitate developments but are merely seen as an additional administrative burden which key partners do not engage with.
- Effective governance structures and accountability arrangements are not in place for all areas of partnership working including CHPs, regional planning groups and Joint Future arrangements. It could therefore be difficult for boards to obtain assurance that all areas of governance are being met particularly clinical governance standards where there is no one body responsible for delivery.
- Partners are unclear as to how community planning arrangements, Joint Futures and CHPs should interlink leading to areas which neither party considers as their responsibility or areas where more than one party develops an initiative which leads to duplication of effort.
- Resources identified for joint working are insufficient to deliver the services and joint funding arrangements have not been fully endorsed by partners.
- Arrangements are not in place to share information across organisational or professional boundaries and a joint performance management framework is not in place resulting in poor and untimely decision making.

- Regional partnerships are seen merely as an additional level of bureaucracy and do not achieve better quality joined up services, equitable access or value for money. Lines of accountability are unclear and clear communication arrangements do not exist.
- Regional partnerships fail to strike the right balance between regional and local priorities, the local needs of participating NHS boards are not met and the necessary linkages with MCNs do not operate effectively.

What are the key issues for local auditors?

84. These include

- The board is able to demonstrate partnership working and joint service delivery. Where limited progress or weaknesses have been identified. Action points have been agreed with appropriate timescales for implementation by the appropriate partner member.
- Partners have agreed appropriate and effective governance arrangements and clear lines of accountability exist between partners including Joint Future partners, community planning partners, regional planning groups and CHPs.
- The board continues to consider Joint Future issues at meetings and there are clear links between how CHPs and joint future partnerships are operating. The responsibilities of each are clearly understood.
- Effective risk management systems, including systems of internal control are in place. Risk management systems are supported by, and complementary to, the risk management strategy of each partner.
- Effective communication mechanisms for information sharing between partners have been established to facilitate efficient service delivery. Changes in service provision are discussed and agreed with all partners.
- A CHP performance management framework is being developed or is in place, with clear links to the local joint framework for partnerships. Outcomes and the data needed to support these have been identified. Reporting lines and timescales are clear.
- There is evidence of improved services as a result of the work of the Joint Future groups, community planning partnerships, regional planning groups and CHPs.
- There is a viable and agreed financial framework for all levels of partnership working and resources and priorities have been agreed in line with partnership agreements.

Information Management

Background

85. In line with the UK Government's e-Government policy, the Scottish Executive agreed in 2000 that IT should be used to provide better, more efficient public services. The SEHD issued the national e-health strategy for 2004-2008 in April 2004. This describes its vision of e-health but, unlike the previous national IM&T strategy and its supporting documentation, it does not give details of programmes to support how this vision will be implemented.

86. Information governance is included in the NHS QIS national standards for clinical governance and risk management. This includes standards on management of personal information, consent to share information and links to clinical governance arrangements. Best value guidance requires an information governance strategy. ISD is responsible for health information, statistics and IT services nationally. NHS QIS and ISD have prepared detailed information governance standards that provide direction and operational support for NHSiS organisations. These standards are supported by a self-assessment framework to be completed by each NHS board.

87. *Delivering for Health* describes the main actions to be taken to implement the recommendations of the Kerr report. This identifies the implementation of national Electronic Health Record (EHR) as one of the key actions. The EHR is also known as the Single Patient Record (SPR).

88. In March 2006, the SEHD re-focused the e-Health Strategy Board as a sub-group of the Health Department Board. This Board will oversee the development of the Strategy and ensure alignment with *Delivering for Health*.

89. In July 2006 the SEHD published an updated Information Security Policy Statement supported by a range of principles covering authority, accountability, assurance and awareness. Chief Executive Officers are directly accountable for ensuring compliance with this policy.

90. The National IT Services contract is being re-tendered. The new contract will be formally signed this year, and all services will migrate from the existing to new supplier by March 2007. The current supplier (Atos Origin) has been named as the preferred supplier for the new contract. This new contract will have different terms and conditions.

Why is it important?

91. Information is a key resource for the NHS to allow it to manage services effectively. Capturing, interpreting, managing and reporting appropriate and up-to-date information are critical to redesigning and modernising services successfully. Boards must operate and support various systems such as

payroll, electronic ledger and e-procurement. The PECOS system is the standard application for e-procurement in the health sector however there have been difficulties with the implementation of PECOS and this has slowed progress in fully implementing the system throughout NHSiS.

92. The Audit Committee and the Health Committee of the Scottish Parliament have been critical about NHSiS's quality and coverage of information and both have expressed concern about the ineffective use of IM&T within NHS boards.

93. There are a number of challenges facing NHSiS as it implements *Delivering for Health*:

- The corporate approach detailed in *Delivering for Health* is a significant cultural change and will require strong leadership to plan and implement.
- Stakeholder engagement needs to improve to ensure that services remain patient-centred.
- Existing good practice in programme and project management need to be consistently applied throughout NHSiS.

94. Information is a key resource for NHSiS to be able to manage services effectively. Capturing, interpreting, managing and reporting appropriate and up-to-date information are critical to successfully redesigning and modernising services. There is also a growing requirement to integrate the full range of patient and staff data capture systems in use throughout the NHS so that patient care is delivered in a seamless way. The Scottish Care Information and the SWISS repositories for patient and staff data are current examples of this. The fact that the Community Health Index number is not yet used throughout NHSiS presents a continuing challenge to the integration of patient-centred information.

95. e-Health will bring changes which will impact on the way services are delivered, for example, through e-procurement, tele-medicine and the EHR. This will affect organisational structures across NHSiS and partnerships with other public bodies. The introduction of CHPs requires closer integration between NHSiS and local authority systems. Sharing information securely with these partners is becoming an increasing operational requirement. The Data Protection Act 1998 and the Freedom of Information (Scotland) Act 2002 also mandate effective information management.

96. Preparations are underway to implement shared support services. Details of the systems to be implemented are as yet uncertain, however it is clear that this will be staggered and take place throughout the year. This will impact on the operation of IM&T services.

97. Under the terms of the Civil Contingencies Act 2004, NHSiS bodies have specific business continuity responsibilities, including performing risk assessments, developing and maintaining business continuity plans, publishing planning information and operating a crisis communication system.

What are the current operational risks and risk areas?

98. These include:

- Information management is not given sufficient priority at strategic level in the board and across NHSiS and there is insufficient management direction and accountability for IM&T at board level. There is inadequate and/or infrequent reporting on information management at senior level.
- A local e-health strategic plan does not exist, or does not fully support the national e-health strategic vision. There is a lack of commitment by the board to ensuring that local strategy integrates with national strategy. Where a strategic plan exists, the costs and resources for implementing it are not fully evaluated and planned for.
- NHSiS is not successful in integrating systems and making the SPR and the Emergency Care Summary (ECN) work within the available resources and timescales.
- There is insufficient leadership and input from frontline staff; insufficient central leadership to ensure that local systems are joined up into a coherent national system; and insufficient programme and project management, in particular to manage the local element of national implementation projects. There are risks that the ongoing management of systems at both national and local levels in the short term does not achieve integration of IT systems.
- Information could be used inappropriately. The Caldicott Guardians already in place provide the governance structure for patient information. Changes made to the availability of information through the ECS and ultimately the SPR will require a greater emphasis on national information security standards and assurance.
- The board does not complete the self-assessment against the national information governance standards or does not comply with the standards.
- Systems may not be secure nor supported by tested business continuity and disaster recovery plans. Business continuity and contingency arrangements do not keep pace with changing operational and business environments. For example, the implementation of single system working and the introduction of CHPs.
- Operational risks have not been identified and plans put in place to address them. These include IT systems that are incompatible, leading to problems in sharing and transferring data; insufficient data retrieval systems; staff without the necessary knowledge or skills to implement, operate and administer new technologies; and IM&T asset registers that are inaccurate or out of date.

What are the key issues for local auditors?

99. These include:

- Information requirements of NHS boards, divisions, services and CHPs have been established and plans are in place to ensure that a local e-health strategic plan is developed to support these and to integrate with national strategy. Arrangements are in place to ensure that local information requirements meet or exceed national information requirements, and that national data standards are met.

- IM&T issues are given sufficient priority and are reported at the appropriate level and frequently enough within the board to ensure the IM&T strategy is delivered. The board has identified key roles including a director of clinical information, a head of e-health/IM&T and an IT security officer. Financial plans identify funding streams and expenditure budgets for e-health initiatives.

- Measures are in place to ensure that business continuity and contingency plans for all critical areas are developed, tested and reviewed and that an IM&T security policy is in place. Contingency plans include data storage and sharing data between partners.

- Arrangements are in place to ensure service continuity during the period of transition to the new National IT Services contract. Monitoring arrangements are in place to ensure that appropriate levels of service are provided by the National IT Services contract.

- The board complies with, or has plans to move to compliance with, the national information governance standards. Codes of practice are in place to govern and control data exchange with other organisations. Measures are in place to ensure that the local information security policy aligns with the NHSiS information security policy.

- Policies, procedures, working practices, support and backup arrangements for IM&T systems used by all staff, including GPs and staff working in CHPs, are in place.

- Appropriate development plans and funding are in place to ensure IM&T skills and staffing establishments are sufficient to support service modernisation. There are performance and quality targets in place to monitor the realisation of benefits derived from the implementation of IM&T systems.

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Glossary

Agenda for Change	A UK-wide plan to introduce a 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 Minister for Health and Community Care. The basis for these reviews are the HEAT targets as well as independent assessments of performance by, for example, local partnership forums.
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 £5000) 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.
Community Health Index (CHI) number	A CHI is a unique numeric identifier that is allocated to each patient registered with a GP in Scotland.

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.
Community Planning Partnership	Multi-agency groups established by each local authority. Their aim is to improve services and the quality of life in the local authority area. There is a statutory duty on NHS boards to participate.
Consultant contract	The new pay, terms and conditions negotiated on a UK-wide basis for NHS consultants.
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.
Electronic Health Record (EHR)	A patient's medical record in an electronic format, accessible by computers on a network for the primary purpose of providing health care and health-related services. Information in an EHR includes documents relating to the past, present or future physical and mental health and condition of a patient, medical test reports.
Emergency Care Summary (ECS)	This is part of the SEHD's Electronic Health Record strategy. It provides essential patient information to out-of-hours-services including NHS 24.
Financial balance	Where income received is equal to expenditure on an ongoing basis
Funding gap	The difference between the income and expenditure that is needed on a recurring basis to pay for operational activities. This excludes any one-off funding from the SEHD and any planned savings.

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 SEHD. Performance against these standards is reported with the board's annual operating and financial review and is discussed at the annual review.
Information Services Division (ISD)	ISD is a division of NHS National Services Scotland. It provides analysis, charts and tables of Scottish healthcare statistics.
Independent Sector Treatment Centre (ISTC)	These are private-sector owned treatment centres that are contracted within the NHSScotland. They perform common elective (ie, non-emergency) surgery and diagnostic procedures and tests in the same way as NHS hospitals.
Kerr Report	This is a report by the Advisory Group on Service Change in NHSScotland. It was chaired by Professor David Kerr. The report develops a national framework for service change in line with the aims of the *Partnership for Care* to develop sustainable specialist services along with more local services delivered in community settings.
Knowledge and Skills Framework (KSF)	This defines and describes the knowledge and skills that NHSiS staff need to apply in their work. It is used as the basis for the review and development of all staff covered by Agenda for Change.
Local Delivery Plan (LDP)	These assist the boards and the SEHD in managing the delivery and performance of health services. They contain key performance targets and measures
Local Improvement Targets (LIT)	These targets are part of the Joint Future agenda. Local partnerships set their own targets which contribute to improving joint community care services.

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 and boards' performance against these standards.
Partnership for Care	Published in February 2003, this Health White Paper focuses on the promotion of health in the broadest possible sense and the creation of a modernised, patient-focused health service that is fit for the 21st century.
Priorities and Risks Framework (PRF)	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 the sector specific national priorities and risks.
Private Finance Initiative (PFI)	The UK Government's initiative to encourage the development 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.

Ring-fenced funding	Funding provided for a specific project or purpose. For example, drug misuse schemes, drug and alcohol prevention, HIV prevention or one-off income such as capital receipts.
Scottish Executive Health Department (SEHD)	The SEHD is responsible both for the NHS in Scotland and the development and implementation of health and community care policy. The SEHD oversees the work of the 14 territorial health boards and 9 special health boards.
Single Patient Record (SPR)	Also known as the Electronic Health Record.
Scottish Workforce Integrated Strategic System (SWISS)	This system aims to provide accurate and consistent information about the NHSScotland workforce.
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.

Priorities and Risks Framework

A national planning tool for 2006/07 NHSScotland audits

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