Priorities and Risks Framework

A national planning tool for 2007/08 NHSScotland audits

November 2007

Auditor General for Scotland

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- further education colleges
- Scottish Water
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Introduction

Context

1. There have been important changes in the healthcare environment since 2006/07. Not least among these is a change in the Scottish Government, which brings with it a change in emphasis in Health issues. The new Scottish Government has issued a consultation paper on the future direction of care entitled *Better Health, Better Care* (Scottish Government, 2007). This document gives an overall summary of healthcare priorities, including delivering care as locally as possible, maximising efficiency and productivity, tackling health inequalities and working in partnerships to provide anticipatory care and improve services for long term conditions. Where applicable, these changes have been reflected in this document.

Audit approach

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

3. 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 are the links to Audit Scotland's priorities?

4. The PRF contributes to Audit Scotland's three priorities of supporting effective democratic scrutiny, maximising the value of the audit and building an effective and efficient organisation by helping auditors to understand the challenges, demands and opportunities facing NHSScotland and focus on the issues that really matter.

What is the role of the PRF?

5. 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 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.

6. 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?

7. Sector specific PRFs are developed each year. Unlike previous years, a planning workshop was not held for 2007/08 as the key risks facing the NHS in Scotland are substantially the same as those identified in 2006/07. This does not reflect a diminution of risk across the NHS, rather it reflects a common understanding on what those risks are. The format of the document has been amended in the light of experience gained in previous years of applying the approach. We will continue to keep under review our approach to the development of the PRF and a more extended process of development may be appropriate in another year.

How will auditors use the PRF?

8. 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.

9. 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?

10. 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.

Future developments

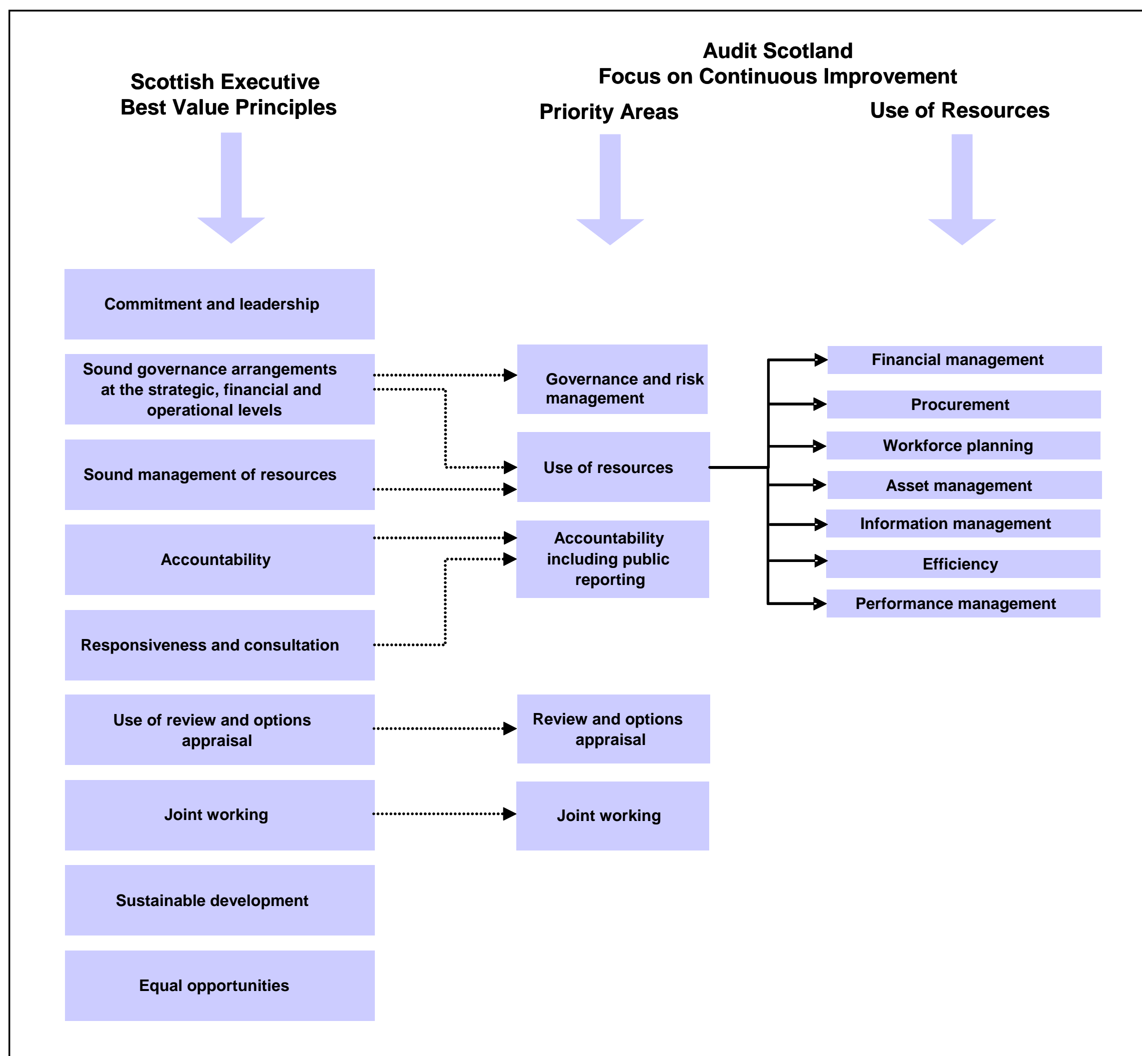
11. Audit Scotland is in the process of developing its approach to the audit of best value and continuous improvement in the wider public sector, including NHSScotland. The approach will:

    - allow flexibility and proportionality in application at individual bodies;
    - be developed and delivered within existing audit resources, maximising the value we get from current resources by joining up our work more effectively; and
    - use the annual audit process as a building block, and draw on overviews and other national reporting mechanisms.

12. Using the Scottish Executive's nine best value principles as a foundation, five priority areas have been selected for the development of a series of audit toolkits over time (see exhibit 1 overleaf). Early activity will focus on toolkits to audit the 'use of resources', with some of these being piloted during 2007/08.

Exhibit 1 – The Best Value audit: priority areas for development

The audit approach aligns core audit activity with the Best Value principles



Source: ASG/PRG (Health and Central Government)

13. The approach to reporting on the delivery of best value at individual bodies is likely to evolve over time, but in the early years will be based on a mix of local reporting through the annual audit report and public reporting through the overview report and thematic national studies.

14. The PRF already incorporates key elements of best value criteria and we intend to review the role that this planning document will play in the future as part of the overall approach to the audit of best value.

Service Redesign and Sustainability

Background

15. A new SNP-led government took office in May 2007. The Health portfolio has been expanded into Health and Wellbeing, encompassing key determinants of health, such as sport, housing, and social inclusion. The government's aim is to create new opportunities for cross-cutting working and a more radical and inclusive approach to achieving shared objectives. The government has also created a Minister for Public Health.

16. In August 2007, the Cabinet Secretary for Health and Wellbeing launched a consultation document, entitled *Better Health, Better Care* seeking views which would help shape an action plan to achieve the government's objectives. The approach builds on the views expressed in the 2005 report, *Building a Health Service Fit for the Future* and the model of care it proposed, which shifts the balance of care away from the acute services and into the community. The stated aim is to "help people to sustain and improve their health, especially in disadvantaged communities, ensuring better, local and faster access to health care."

17. The key aspects of the strategic vision include:

    - improving patients' experience of care, by delivering care as locally as possible, including a presumption against centralisation;
    - securing best value by maximising efficiency and productivity to ensure services are sustainable;
    - encouraging greater personal responsibility for health and wellbeing;
    - tackling health inequalities;
    - working in partnership to provide anticipatory care and improved services for long-term conditions; and
    - giving children the best possible start through early intervention and prevention.

18. The government intends to publish a detailed action plan for Health and Wellbeing by the end of December 2007. However, it has already taken action in a number of these areas and has, for example:

    - announced the reversal of the decision to close A&E services at Monklands and Ayr hospitals;
    - proposed the independent scrutiny of key service change and redesign proposals;
    - set up the Sutherland review to look at the funding of free personal and nursing care;

- made changes to the measurement of waiting times and reiterated the need for boards to meet the 62-day cancer waiting time target by December 2007; and
- begun discussions with NHS Boards and the BMA to increase flexibility and improve the delivery of out of hours care.

19. 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. The recent report from Audit Scotland on Primary Care Out of Hours Services further supports the need for change by raising questions over the sustainability of the service in its current form in the longer term. Boards will also 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, front-line services, with key service change proposals being subject to independent scrutiny. A national study is also due to be completed by Audit Scotland in Autumn 2008 on asset management, including a consideration of the impact of service redesign on the use of the NHS estate and its assets.

20. 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);
    - 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, including the consideration of patient needs and expectations;
    - significant service redesign activities will 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; and
    - ensuring that there is sufficient management capacity to deliver change successfully.

Key risks

21. 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 health care, and an improvement in the patient's experience, as outlined in *Better Health, Better Care*. If internal and external stakeholders (such as 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. The board should be able to show that:
  - it has a vision of where the organisation will be in the next 3 – 5 years and beyond, informed by an understanding of internal and external stakeholders' needs and national priorities and policies;
  - it is engaging with stakeholders to gain their support and obtain their involvement in service redesign; and
  - 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 plans published are financially and operationally achievable.
- Financial recovery plans do not fully consider future service delivery or appropriately consider financial pressures. Financial recovery 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; and
  - prepare benefits realisation plans e.g. for pay modernisation initiatives to demonstrate actual benefits achieved.

Project management

- Poor programme and project management results in late or inefficient and ineffective project delivery for key redesign projects. The board should have assessed its management capacity to deliver its vision and programmes of service improvement, including executive leadership, risk and change management, programme and project management requirements, and workforce requirements.
- NHS Boards are constrained in their ability to redesign services due to inflexibility imposed by PPP/PFI or other long-term contracts. The new Scottish Government's approach in this area is still developing, however, the board should have established robust project management systems to ensure relevant processes are followed, including option appraisal, consideration of PPP/PFI or related arrangements, and implementing a mechanism for reviewing the effectiveness of these processes.

Prioritisation 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.

Partnership Working

Background

22. 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 NHSS fulfil the requirements of *Delivering for Health*. This notes that joint working will continue with local authorities, between NHS organisations and also with other external partners.

23. The need to work collaboratively is enshrined in both the Partnership Agreement (Scottish Executive, 2003) and in *Partnership for Care*, which states that improvements in the health of the people of Scotland cannot be achieved by SGHD or the NHS Boards alone. 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.

24. *Delivering for Health* also introduced the concept of Community Health Partnerships (CHPs) as the main vehicle for improving services at a local level. CHPs were effective from 1 April 2005, although some boards have taken this further and developed Community Health and Care Partnerships (CHCPs). A variety of CHP models are now therefore in place throughout NHSS although, in the main, they provide a focus for integration between primary care, specialist services and with social care. CHPs are also viewed as the main NHS agent through which the Joint Future agenda is delivered in partnership with local authorities and the voluntary sector. Audit Scotland's local auditors have recently carried out a number of reviews of newly developed CHPs/CHCPs across Scotland. These show that these developments are at an early stage and that there is a need to demonstrate a planned and effective transfer of resources from the acute service to primary and community care.

25. Further, *Partnership for Care* recognised that only through 'better planning and co-operation at a regional and national level' will it be possible for NHSS to provide the full range of modern health services. The support and potential of Managed Clinical Networks (MCNs) is also crucial to regional planning. 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.

26. Partnership working between NHSS 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 NHSS in a bid to meet waiting times by individual health boards. In addition, the Golden Jubilee National Hospital is used to alleviate waiting times.

27. Moreover, in terms of the Local Government in Scotland Act 1973 there is a duty on health boards and other public sector organisations to participate in the community planning process although the lead role remains with local authorities.

28. More recently the Cabinet Secretary for Health and Wellbeing in the discussion document *Better Health, Better Care (2007)* emphasised the need to work in a co-ordinated way across Government to adapt and reinforce traditional values of care, community and public services. This requires a health service that works together with its partners, places the patient at the heart of everything it does, integrates care, realises efficiencies and ensures the highest standards of quality and safety.

Key risks

29. These include:

Commitment

- CHPs are not seen as a key driver to improve local health services, support service redesign and facilitate community based care. The board should be able to demonstrate leadership in partnership working and joint service delivery. They should also be able to provide examples where joined-up service delivery has made a difference at a local level.

Clear lines of responsibility and accountability

- Partner organisations are unclear about their areas of responsibility and delegated authority. The 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.
- Partner organisations lack clarity as to how community planning arrangements, Joint Future and CHPs should interlink thereby leading to inefficiency and possible duplication of effort. Arrangements should be in place to ensure that joint service delivery objectives have been agreed amongst partners and a development plan, or equivalent, put in place for their implementation. This plan should have clear links to the board's Local Delivery Plan, Council (or Service) Plan, Community Plan and the plans of other partner organisations.

Resources

- Resources identified for joint working are insufficient to deliver the services and joint funding arrangements have not been fully endorsed by partners. The 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 budgets have been agreed amongst 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; and
- 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. CHPs 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 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; and
  - performance monitoring arrangements are sophisticated enough to provide evidence of improved service delivery as a result of partnership working.

Partnership working

- Regional partnerships are seen as an additional level of bureaucracy and do not achieve better quality joined up services, equitable access or value for money. Boards should be able to provide examples of regional partnership working and how these have helped improve service delivery. Also, boards should be able to provide evidence of linkages with Managed Clinical Networks and gauge their effectiveness.

Governance

Background

30. 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.

31. 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.

32. *Delivering for Health* also 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 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.

33. More recently the Scottish Government, in its discussion document *Better Health, Better Care,* has promoted the idea of direct elections to health boards as a means of strengthening governance.

34. The key components of governance within which NHS Boards are required to operate are financial governance, staff governance and clinical governance.

35. **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.

36. **Staff governance**. This refers to a system of corporate accountability for the fair and effective management of all staff. NHSS'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.

37. **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 Quality Improvement Scotland (NHS QIS) is charged with improving the quality of care delivered by NHSS. NHS QIS carries out an annual programme of reviews to assess all boards against the *Standards for Clinical Governance and Risk Management* (October 2005). Robust clinical governance structures will be essential to demonstrate NHS Boards' effectiveness in meeting patients' needs and patients' safety.

Key risks

38. 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 (e.g. the Audit Committee handbook).

Scrutiny

- Information submitted to the board and committees is insufficient for members to assess the impact of decisions on resources and performance. Reports submitted to the board and 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 officers and hold them to account, and that new non-executive directors receive induction training covering their scrutiny role.

Integrated planning

- The board's plans are not aligned and fail to adequately address service modernisation and redesign. The board should have a Local Delivery Plan in place which is underpinned by a financial strategy that includes detailed and realistic plans linked to available resources and is aligned to service objectives. Workforce plans should be integrated with the Local Delivery Plan.

Consultation

- Public involvement and stakeholder and staff consultation is not integrated within the policy and decision-making processes of the board. 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.

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 organisation'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; and
  - 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 on 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, and
  - it has put in place clear plans to meet the requirements identified from any NHS QIS 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, regional planning groups and Joint Future arrangements. The board should be able to show that it makes use of the self-assessment tool, prepared by Audit Scotland, to review governance arrangements in Community Health Partnerships. 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.

Financial Management

Background

39. Investment in NHSS is increasing each year, from almost £9 billion spent in 2005/06, to £10 billion in 2007/08. However, this level of increase is not sustainable in the longer term.

40. 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. NHSS as a whole continues to report an overall cumulative surplus, but a small number of NHS Boards have recorded annual and cumulative deficits, and others are forecasting financial difficulties in future years.

41. Audit Scotland has highlighted concerns about financial management in the NHSS in recent national overview reports. In addition, a series of local studies were carried out by auditors in 2006/07, raising concerns about longer term financial planning, funding gaps in NHS Boards' financial plans, financial plans not always linked to other planning activities, reliance on non-recurring revenue to fund recurring activities, and the non-achievement of Cash Releasing Efficiency Savings (CRES).

42. Board members, including non-executive directors, have a key role in overseeing financial management, ensuring that robust financial plans are established, financial performance is monitored, and action is taken to ensure that financial targets are met.

43. 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* and any initiatives proposed by the new government;
    - the loss of the facility to make capital to revenue transfers;
    - the change in the treatment of profits on disposal of assets, which now means that these are allocated to capital income, removing any revenue windfall received from asset sales;
    - the size and age of the NHSS estate, including the ongoing financial impact and conditions of the use of the PPP/PFI route to deliver improved facilities;
    - poor cost information available locally and at a national level (this factor may have become more significant following the introduction of national tariffs); and
    - underlying cost pressures, such as increasing energy costs, the general impact on healthcare costs of newly developed treatments and the effects of an ageing population nationally.

44. In addition, there are a number of national issues which provide further challenges to financial management within the NHSS:

- the Efficient Government initiative is a five year programme to reduce waste, bureaucracy and duplication in the public sector. Targets have been set for total cash releasing savings of £350 million and time releasing savings of £173 million to be achieved by the end of 2007/08. There are a number of national initiatives designed to generate savings in areas such as sickness absence and procurement. In addition, boards are also expected to propose their own savings plans in areas such as estates and facilities, workforce arrangements, and service redesign;
- the impact of Equal Pay regulations has led to boards facing significant costs relating to backdated pay increases. By the end of 2006/07, the Central Legal Office was 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; and
- the NHSS Shared Support Services Programme has been recently revised. Its aim is to bring all boards up to a common level of technology and core processes for finance functions. Some pathfinder Health Boards have agreed to test and implement new processes, and it will be some time before these shared support services are fully established. However, Boards will need to consider the impact of this initiative on their longer-term financial plans.

Key risks

45. These include:

Long-term strategy

- 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 financial recovery plans, and how these will be reported, should have been agreed with the SGHD.
- 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. The board should have clearly identify financial risks within its risk registers and ensure that these are effectively managed.
- 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.

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 have consulted 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, CHPs and PPP/PFI arrangements.
- 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.

Savings plans

- Savings plans are unrealistic and short-term, and tend to be based on non-recurring sources rather than reducing underlying expenditure. 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:
  - it does not rely on non recurring sources to meet its savings targets;
  - savings plans focus on recurring sources, are transparent and, where appropriate, include specific actions required to meet Efficient Government targets; and
  - it is making progress in achieving its planned savings.

Performance Management

Background

46. New delivery and performance management arrangements for the NHS were introduced in 2006 by the then SEHD. These are based on Local Delivery Plans (LDP), which are structured around a hierarchy of four key Ministerial objectives, 28 key targets (HEAT targets covering Health Improvement, Efficiency, Access, and Treatment), and 31 supporting measures.

47. 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.

48. 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 NHS Boards to monitor performance against the key targets on an ongoing basis[1]. NHS Boards' performance against these targets is a key component of the Annual Reviews with the Cabinet Secretary.

49. NHS Boards are expected to monitor and report progress against other key targets and initiatives, including Efficient Government and pay modernisation[2]. 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.

50. In November 2006, the SEHD Directorate of Delivery issued guidance stating that NHS Boards' performance management arrangements are expected to incorporate the core principles underlying Citistat approach to performance management. These are detailed in the key risks section.

51. In August 2007 the Scottish Government published *Better Health, Better Care: A discussion document*. This sets out a strategic vision for health care and poses questions about what key performance targets would best focus NHSScotland on:

    - improving patient and carer experience;
    - delivering best value for patients;
    - creating the environment in which good health can flourish;
    - tackling health inequalities;

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

- anticipating health problems and improving care for people with long-term conditions;
- providing early interventions and helping offer children the best possible start in life; and
- securing continuous improvement and quality (including how the new waiting time target should be defined to maximise its potential for improving the quality of patient care).

Key risks

52. 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. NHS 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. The system should be comprehensive and ensure that the board is able to monitor performance in key service areas;
  - the performance management system leads to continuous improvement in service delivery e.g. by developing action plans following local or national reviews and following up action plans to ensure progress;
  - the performance management systems consider the economic, efficient and effective use of resources;
  - the board has allocated responsibility for performance management to a specific committee / executive director(s), with written remit outlining responsibilities and expected actions / outputs and timescales; and
  - the performance management system gives sufficient priority to delivering sustainable services that meet the needs of the local population.

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:
  - the board regularly collects and reports accurate, relevant data;
  - the board analyses this data to provide an accurate and timely view of activity and outputs that supports progress to well-defined outcomes;

- 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, focussing on the data and actions to improve performance; and
- there is active follow-up from the data and the meetings, overseen by senior management.

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; and
  - the board appears on track to meet the performance levels agreed in the LDP, whether there are risks to them delivering and whether these risks are being managed.

Partnership working

- CHPs and joint partnerships do not have robust performance management systems that are well integrated with overall board systems. Boards do not work in partnership with CHPs and other partners, including appropriate public involvement. The board should be able to demonstrate that:
  - local performance targets are identified and agreed with local partners, operating divisions and the public;
  - the board considers and complies with relevant principles of patient focus and public involvement within its performance management framework;
  - the performance management arrangements of CHPs and joint partnerships (within and outwith the NHS) are linked to the board's overall performance management arrangements;
  - CHPs and joint future partnerships have robust performance management systems that effectively manage performance by ensuring that expected outcomes are clearly defined and that key indicators of performance are identified, regularly monitored and reported, and that need for improvement is acted on;
  - CHP and joint partnership performance management arrangements track progress against key targets specified in the LDP; and

   - local targets for community care are linked to local improvement targets required under the Joint Performance Information Assessment Framework (JPIAF).

Efficient Government

- The board does not monitor time-releasing and 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 and time-releasing savings.

Public reporting

- NHS Boards do not properly report performance against key targets to the public and other external stakeholders, including detailed analysis of performance against key targets in the operating and financial review accompanying the financial statements.

People Management

Background

53. Better workforce planning and extended roles for staff are essential to support the central NHS aim of continuing to develop community based and seamless care for patients. To change the way the NHS delivers services, staff increasingly need to work jointly across specialties, sectors and agencies.

54. The development of CHPs means that 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.

55. In December 2006 the annual *National Workforce Plan* was published, which sets out details of the current workforce and specifies actions for the future. As part of this work the SGHD expects boards to link workforce plans with service and financial plans, and for clear links to workforce planning to be included as part of boards' LDPs. Boards are required to produce annual workforce plans.

56. Boards have implemented the major pay modernisation contracts but the focus on achieving the aims and proposed benefits of the contracts will continue. Audit Scotland's national report on Implementing the NHS Consultant Contract, for example, highlights the importance of linking pay modernisation schemes with service priorities and improvements in patient care. The impact of these contracts and of Modernising Medical Careers will continue to affect boards, and the monitoring of doctors hours against the European Working Time Directive must continue.

57. Equal pay claims lodged following on from the Equal Pay Act (2004) are likely to be a significant financial pressure for Boards, and back pay for any changes may apply. A central Equal Pay Unit, hosted by NHS NSS, has been created to help establish consistency in how equal pay claims are handled across Scotland.

58. Staff governance focuses on how the NHS manages staff and how staff feel they are managed within the NHS, and is one of the three pillars of governance (along with financial and clinical governance). In June 2007 the SEHD published the third edition of the *Staff Governance Standard*. The standard applies to all NHS staff including staff involved in joint futures and CHP work. There are three main features:

   - a self-assessment checklist is included as part of the standard which all Boards must complete and submit to the SGHD annually in March;
   - a minimum data set is specified within the standard; and

- a self assessment audit tool which will be subject to peer review and action plans will be followed up and reported upon by auditors.

59. Information Services Division (ISD) continues to publish workforce data from the Scottish Workforce Information Standard System (SWISS). 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.

Key risks

60. These include:

Workforce planning and control

- 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, or control its recruitment and retention activities. 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 an annual workforce plan and contributed 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*
  - local arrangements in place to take forward the workforce plans;
  - an established staff appraisal system which seeks to identify training and development needs, and has sufficient resources to meet these needs;
  - joined up workforce plans with financial and service plans;
  - financial plans that include up to date and accurate forecasting for pay modernisation and that the board is actively managing the impact; and
  - appropriate pre-employment checks which are carried out on all staff, including those from overseas, to ensure that they are suitable employees and have the relevant

qualifications, references, work and residence permits, and assurances from Disclosure Scotland or other police checks.

Management capacity

- 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 information

- 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 and the staff governance standard; and
  - contingency plans are in place to address any deficiency in workforce data.

Pay modernisation

- Insufficient funding is available to fully implement the pay modernisation agenda and the extra funding for pay modernisation does not deliver value for money. There is a risk that boards do not have procedures in place to assess and demonstrate how they are 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; and
  - 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.

Equal pay

- Developments such as Agenda for Change, redesigning 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 against boards. There is a risk that boards do 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, taken steps to reduce this risk and put in place plans to deal with such claims; and
- it has taken action to harmonise terms and conditions for staff working as part of joint teams but with different employers.

Self-assessment and monitoring

- There is a risk that the board does not meet monitoring and assessment requirements relating to workforce management. The board should be able to demonstrate that:
  - it has completed the self assessment audit tool for the staff governance standard annually and that this is assessed and reported in accordance with HDL(2004)39;
  - it has processes in place to address any issues included in the action plan produced from the self-assessment audit tool for staff governance; and
  - it continues to monitor doctors' hours in accordance with the New Deal and European Union Working Time Directive.

SWISS database

- 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. The board should be able to demonstrate that contingency plans are in place to manage the risks of SWISS not delivering the information expected, or of it not delivering to expected timescales.

Information Management

Background

61. Information is a key resource that allows NHS Scotland to manage services effectively. Capturing, interpreting, managing and reporting appropriate and up-to-date information is critical to redesigning and modernising services successfully. It is important that boards understand the value of the data they hold, and ensure that it is stored securely. Current information legislation[3] mandates effective information management and the requirement to have robust business continuity planning in place.

62. NHS QIS and ISD have prepared information governance standards for NHSScotland covering management of personal information, consent to share information and links to clinical governance arrangements. These standards are supported by a self-assessment framework[4]. A recent NHS circular[5] outlines how information governance standards are to be benchmarked in GP practices.

63. 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 Executives are directly accountable for ensuring that their NHS Boards comply with this policy.

64. The Audit Scotland report *Informed to Care* highlighted that the national eHealth strategy should be updated, the role of the national programme office should be extended to ensure consistent project management standards are used for all national programmes, and the identification and monitoring of capital and revenue spend on IM&T/eHealth could be improved. The eHealth Governance[6] review, conducted by the SEHD during 2006, proposed a number of organisational changes that are now being implemented to address some of these issues.

65. As an initial step towards the development of a financial strategy to support eHealth implementation, the SGHD, in conjunction with NHS Board eHealth leads, has developed an IM&T expenditure template that all boards are expected to complete annually. The first return was expected in August 2007.

66. In *Better Health, Better Care* the Scottish Government states that a new eHealth strategy sharing the vision of how new technology will provide better access to information to improve patient care is to be developed. The eHealth Programme Board is responsible for developing this by spring 2008. eHealth will bring changes to the way in which services are delivered, for example, through tele-medicine and the implementation of a national electronic health record (EHR) or, as it is sometimes known, the

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[3] Data Protection Act 1998, Freedom of Information (Scotland) Act 2002, Environmental Information (Scotland) Regulations 2004, Re-use of Public Sector Information Regulations 2005, the Civil Contingencies Act 2004

[4] The Information Governance Toolkit – a quarterly self-assessment return

[5] PCA(M)(2007)11 – August 2007 – Benchmarking Information Governance and Data Quality Standards in GP Practices

[6] NHS Scotland eHealth Strategy Board, Planning for eHealth Governance, Oct 2006 (the Deloitte report)

single patient record (SPR). This will affect organisational structures across NHSScotland and partnerships with other public bodies. Boards will also be expected to adopt other nationally procured systems which support the EHR system (e.g. ECS, PAS/PMS, PACS, and A&E) to improve data consistency throughout NHSScotland.

67. There is a requirement to integrate all patient and staff data capture systems within NHSScotland so that patient care is delivered in a seamless way. The SCI[7] and the SWISS repositories for patient and staff data are current examples of this. The fact that the Community Health Index (CHI) number is not consistently used presents a continuing challenge to the integration of patient-centred information.

68. The introduction of CHPs and the inclusion of Wellbeing into the Scottish Government's heath portfolio requires closer integration between NHSScotland, local authority, voluntary sector and other partner systems. Sharing information securely with these partners is becoming an increasing operational requirement. One possible solution, the eCare Multi Agency Store (MAS) [8] is being piloted in some boards during the course of 2007.

69. A number of NHSScotland national information systems are provided via the National IT Services contract. A new contract with Atos Origin Alliance (AOA)[9] for an initial term of 11 years commenced on 1 April 2007. The new contract covers additional services, including the IM&T infrastructure for PSD previously provided directly by the NHS National Services Scotland (NHS NSS) corporate IM&T department. NHS NSS manage the contract on behalf of SGHD / NHS Scotland and must provide assurance to all NHS Boards on its effective operation. NHS NSS appointed Scott-Moncrieff from 1 April 2007 to provide this assurance through a SAS70[10] Type II service audit report.

70. The next phase in the NHS Shared Support Services Programme will see all NHS boards using a standard ledger system, operating with a common Chart of Accounts. Over the next two years, boards should work collaboratively in a small number of consortia to develop Pathfinder projects that will implement and test the technological and process solutions necessary to achieve this goal. These consortia have been asked to prepare project initiation documents for agreed Pathfinder projects by November 2007.

[7] SCI – Scottish Care Information – SCI-Store is an information repository used to transfer clinical data securely between different NHS systems
[8] MAS – Multi-Agency Store – a security-controlled database used to store information being shared between partners
[9] AOA – the Atos Origin Alliance, comprising Atos Origin, BT, IBM and Sopra Newell & Budge
[10] SAS70 – Statement on Auditing Standards No. 70, Use of Service Organisations

Key risks

71. These include:

Continuing relevance of IT plans

- 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.

Resources

- IM&T issues are not given sufficient priority and are not reported frequently at an appropriate level to ensure that the IM&T strategy is delivered. The board should have identified key roles including a director of clinical information, a head of e-health/IM&T and an IT security officer.
- Local and national financial plans that identify funding streams and expenditure budgets for eHealth initiatives are not in place. To assist this, the board should complete the NHS IM&T expenditure template.
- Appropriate development plans and funding are not in place to ensure IM&T skills and staffing establishments are sufficient to support service modernisation. The board should be able to demonstrate that that it has addressed these planning and funding issues.

Performance management

- Performance and quality targets to monitor the realisation of benefits derived from the implementation of local and national IM&T systems are not in place. The board should be able to demonstrate that arrangements are in place to monitor delivery of planned benefits.

Information security

- 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. Arrangements should be in place to ensure that information shared with partners is subject to an equally rigorous information security policy when being processed by the partner organisations.
- The board does not fully comply with national information governance standards. To increase compliance with these standards, the board should submit returns via the national information governance toolkit on a timely basis and develop a local action plan to address identified gaps. GPs should also be encouraged to complete and implement local action plans designed to improve information governance and data quality standards within their practice.

Contingency plans

- 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.

National IT services

- Boards are not fully aware of the services available from the new National IT Services contract. Board management should ensure that options available from the National IT Services contract are considered when improving local services. Monitoring arrangements should be in place to ensure that appropriate levels of service are provided by the National IT Services contract.

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Glossary

Term	Definition
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 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.
Citistat	A performance management system developed for the public sector in Baltimore. Its use within the NHSS has been supported by the Scottish Government.
Clinical governance	Arrangements put in place to ensure safe and effective healthcare. NHS QIS reviews boards' clinical governance arrangements.
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.
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.
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 SGHD 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 SGHD. 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.
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
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 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.

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 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 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

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