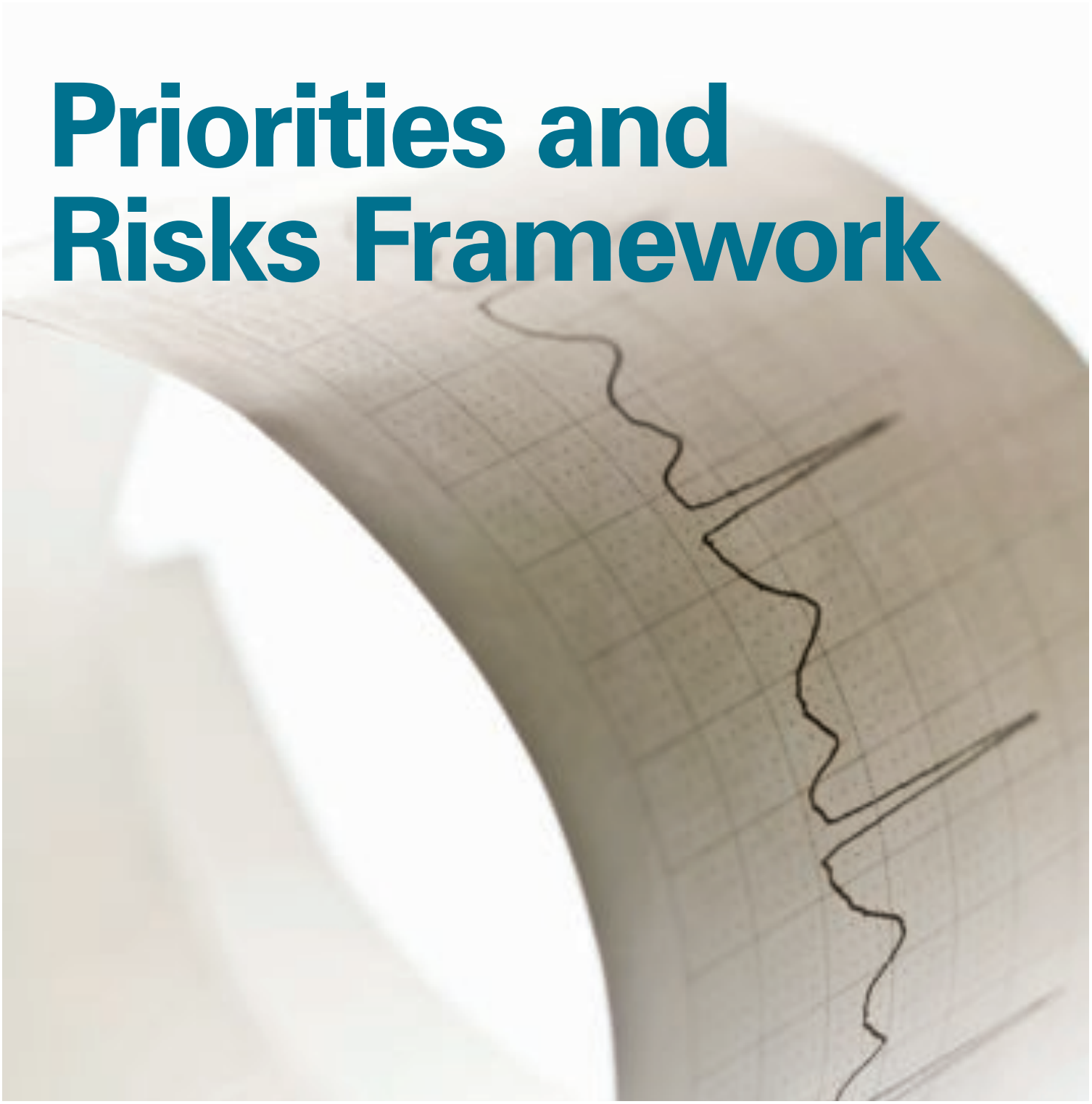
Priorities and Risks Framework



AUDIT SCOTLAND

A national planning tool for 2008/09 NHSScotland audits

October 2008

Auditor General for Scotland

The Auditor General for Scotland is the Parliament's watchdog for ensuring propriety and value for money in the spending of public funds.

He is responsible for investigating whether public spending bodies achieve the best possible value for money and adhere to the highest standards of financial management.

He is independent and not subject to the control of any member of the Scottish Government or the Parliament.

The Auditor General is responsible for securing the audit of the Scottish Government and most other public sector bodies except local authorities and fire and police boards.

The following bodies fall within the remit of the Auditor General:

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

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

Priorities and Risks Framework

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Introduction

Context

1. The Scottish healthcare environment has continued to evolve since we issued the last Priorities and Risks Framework document for Health in November 2007. As the initiatives of the new Scottish Government develop, the future direction for healthcare in Scotland becomes clearer. In particular, the Scottish Government launched the *Better Health, Better Care* Action Plan in December 2007.

2. While this edition of the Priorities and Risks Framework is subtitled "A national Planning Tool for 2008/09 NHSScotland Audits", we intend that it will also serve, with appropriate updates of detail, as the Planning Tool for 2009/10 and 2010/11 audits.

Audit approach

3. 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.

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

What is the role of the PRF?

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 central government. Each PRF 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 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?

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.

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

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

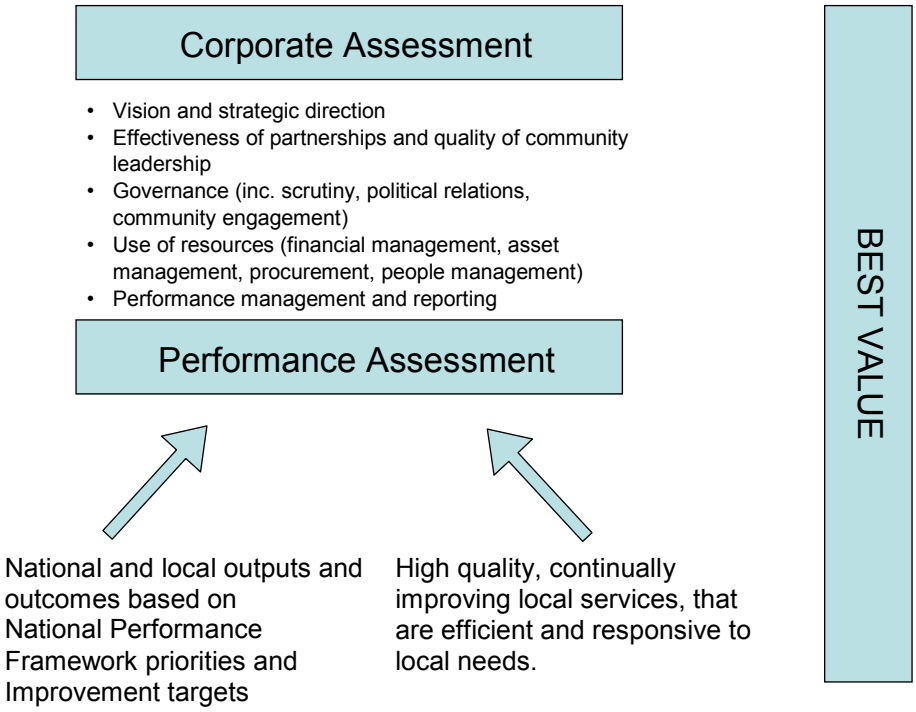
11. An appropriate recording mechanism for the results of the PRF is essential in ensuring local audit plans are supported by appropriate evidence. Auditors will prepare their risk assessment as part of their planning process, identifying and recording the current status of local developments in the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

Future developments – best value

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

13. We intend to adopt an audit framework that is consistent across local government, central government and health, although the application will vary to reflect the differing accountability arrangements. This will focus on the corporate function of a public body and an assessment of its performance (Exhibit 1).

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



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

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

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

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

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

17. To this end Audit Scotland is developing audit toolkits to cover the key BV principles. Our first priority is developing a range of 'use of resources' toolkits covering areas such as financial management, information management and procurement. The toolkits are being developed so that they can be used by public bodies themselves first for self assessment purposes with validation by auditors.

18. The *annual audit report* will make reference over the 5-year period of the audit appointment to specific work on BV and will form part of the evidence available for the annual reviews of each NHS board. The compilation of the annual audit report will be, to a substantial extent, informed by work undertaken in light of the PRF document.

Service Redesign and Sustainability

Background

19. In December 2007, the Cabinet Secretary for Health and Wellbeing launched the *Better Health, Better Care* Action Plan, following the consultation document launched in August 2007. The stated aim of the plan is to "help people to sustain and improve their health, especially in disadvantaged communities, ensuring better, local and faster access to health care."

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

    - the Government has introduced Independent Scrutiny Panels which oversee major service redesign decisions taken by individual boards. These panels have already reviewed revised proposals for the reconfiguration of emergency care within Lanarkshire and Ayrshire, and also proposals for changes to NHS services in the Clyde area
    - waiting times targets have also been a focus for the Government, with the introduction of the 18 week waiting time target from referral to treatment, which all boards must comply with by 2011
    - the Government is also changing the funding mechanisms for large capital projects within the public sector, replacing PFI/PPP arrangements with the Scottish Futures Trust
    - the Government is also proposing to consult on a new Patients' Rights Bill.

21. The impact of these developments will need to be assessed by health boards, and reconciled with their long-term strategies. Service redesign may be required to manage the impact and enable health boards to meet their objectives. Other drivers for service redesign are also becoming more evident. The need to drive efficiencies from current operations is a focus for the majority of health boards, particularly given the efficiency savings targets and the need to meet these on a sustainable basis. Health boards need to ensure that their strategies are achievable within the financial resources available to them.

22. Current population demographic forecasts reinforce predictions of an ageing population over time. Between 2006 and 2031 the Scottish population is projected to age markedly with the number of people in the 60 plus age bracket increasing by 54 per cent from 1.12 million to 1.78 million.[1] This forecast presents an additional challenge to health boards to ensure that their long-term service provision will meet the needs of the whole population.

[1] *Scotland's population 2007, The Registrar General's Annual Review of Demographic Trends,* General Register Office for Scotland, August 2008

23. 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)
- workforce plans and financial plans need to be fully aligned with the clinical strategy to ensure that it can be delivered and sustained
- affordability and the ability to demonstrate best value and benefits realisation need to be considered
- implementation of robust systems to obtain information on current and future service provision will be needed, including the consideration of patient needs and expectations
- significant service redesign activities 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
- ensuring that there is sufficient management capacity to deliver change successfully.

Links to other work

24. Audit Scotland's *Overview of Scotland's Health and NHS Performance 2006/07* (December 2007) examined a range of issues relevant to the consideration of service redesign and sustainability. Its review of out-of-hours services in 2007 also highlights the importance of having robust information to support the redesign of services and changing workforce roles. Audit Scotland is also currently reviewing asset management in the NHS and will publish its findings in early 2009. It also published a report looking at major capital projects across the Scottish public sector in June 2008.

Key risks

25. These include:

Vision and consultation

- Without service redesign the board cannot continue to meet the demands of its patient population, including better, local and faster access to healthcare, and an improvement in the patient's experience, as outlined in *Better Health, Better Care*. If internal and external stakeholders (such as Community Health Partnerships (CHPs), operating divisions, patients, local authorities, regional planning groups, Scottish Government Health Directorates (SGHD)

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

Performance management

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

- provide assurances that redesigned services are safe and are improving the quality of care for patients
- prepare benefits realisation plans and measure achievement against these e.g. for pay modernisation initiatives to demonstrate actual benefits achieved.

Project management

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

Re-allocation of resources

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

Effective Partnership Working

Background

26. NHS boards must be able to demonstrate that they are delivering effective services for patients and their carers and achieving value for money. Working in partnership with other organisations, including councils and the voluntary sector, will help the health service to meet its strategic objectives and to address local needs.

27. *Delivering for Health* (2005) introduced Community Health Partnerships (CHPs) as the main vehicle for improving health services at a local level. The Scottish Executive introduced CHPs from 1 April 2005, although some NHS boards have taken this further and developed Community Health and Care Partnerships (CHCPs). There are different CHP models in place throughout Scotland but they primarily provide a focus for integration between primary care, specialist services and social care. CHPs have a central role in delivering the Joint Future Agenda, in partnership with local authorities and the voluntary sector. Although local arrangements for CHPs/CHCPs vary across Scotland, there is scope for significant amounts of public funds to be managed through partnerships.

28. In *Better Health, Better Care* (2007), the Cabinet Secretary for Health and Wellbeing emphasised the need to work in a coordinated way across Government to develop patient care, and community and public services. The health service must work together with its partners to place the patient at the heart of everything it does and integrate care to realises efficiencies and ensure it achieves the highest standards of quality and safety.

29. The recent move to an outcome-based approach, through the development of Single Outcome Agreements (SOAs) for local government, commits councils to delivering outcomes that they cannot achieve alone. This increases the focus on effective partnership working and community planning between public sector bodies and other local service providers. From April 2009 the Scottish Government plans that all 32 SOAs will be formally agreed between central government, councils and their community planning partners. These changes have been accompanied by the removal of ring-fenced funding arrangements from local authorities. This increases the flexibility available to these bodies, but it also increases the need to ensure that there are very clear funding agreements or budget alignments in place within partnerships.

30. Partnership working between NHS and the private sector is a feature of the delivery of healthcare services in England, in the form of Independent Sector Treatment Centres (ISTCs). The NHS in Scotland has used private hospitals in a bid to meet waiting times for individual health boards.

Links to other work

31. In 2006/07 Audit Scotland's Audit Services Group carried out a number of reviews of CHPs/CHCPs across Scotland. These reviews showed that CHPs/CHCPs were at an early stage of development and that there is a need to demonstrate a planned and effective transfer of resources from the acute service to primary and community care. Audit Scotland consulted on a proposed forward study programme over the summer of 2008, which included proposals for a national review of CHPs/CHCPs to take place during 2008 – 2010. The Scottish Government plans to commission research at the end of 2008 which will examine the impact of CHPs.

32. In August 2007, Audit Scotland published a report on *Managing Long-Term Conditions*. Audit Scotland also plans to publish an overview report on mental health services in Scotland in March/April 2009. Both studies have relevance to partnership working with the local government and voluntary sectors.

Key risks

33. These include:

Commitment and leadership

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

Responsibility and accountability

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

Planning

- Partner organisations lack clarity as to how community planning arrangements, Joint Future and CHPs should interlink thereby leading to inefficiency and possible duplication of effort. Arrangements should be in place to ensure that partners have agreed joint service delivery objectives and a development plan, or equivalent, has been put in place for their implementation.

- Strategic priorities may not be fully integrated within NHS or partners' corporate and service plans. Services may therefore not be working towards agreed strategic priorities. Plans should have clear links to the board's Local Delivery Plan, Council (or Service) Plan, Community Plan and the plans of other partner organisations. The contribution of the NHS to SOAs must also be clear. Plans should not just reflect national priorities but also address local needs.

Resources

- Resources identified for joint working are insufficient to deliver the services and joint funding arrangements have not been fully endorsed by partners. The NHS board should be able to demonstrate that:
    - joint planning is supported by a financial strategy that includes detailed and realistic resources to achieve jointly agreed objectives and priorities
    - pooled 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
    - 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 NHS board should have procedures in place for ensuring that:
    - key performance measures have been identified, and defined, for areas of joint working and these are regularly monitored and reviewed
    - performance management reporting lines and timescales are clear
    - performance monitoring arrangements are sophisticated enough to provide evidence of improved service delivery as a result of partnership working, including through SOAs, and can align to the National Performance Framework.

Scrutiny and Governance

Background

34. 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.

35. 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.

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

37. *Better Health, Better Care* also introduced the policy of Independent Scrutiny of proposals for major service redesign by boards and included consideration of direct elections to NHS boards as a means of increasing accountability.

Governance

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

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

40. **Staff governance**. This refers to a system of corporate accountability for the fair and effective management of all staff. NHSS 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. Boards are required to complete a self-assessment of their compliance with the staff governance standards and these will be subject to assessment by external audit in 2008/09. Staff governance issues are further addressed in the chapter on Capacity to Deliver.

41. **Clinical governance**. In the white paper *Designed to Care*, clinical governance was defined as 'corporate accountability for clinical performance'. It is the system for making sure that healthcare is safe and effective and that patients and the public are involved. NHS QIS is charged with improving the quality of care delivered by NHSS. NHS QIS carries out reviews to assess all boards against the *Standards for Clinical Governance and Risk Management* (October 2005) every three years, and it carries out reviews against the standards as part of a wider specialty or topic review in all boards in the intervening years. Robust clinical governance structures are essential to demonstrate NHS Boards' effectiveness in meeting patients' needs and patients' safety. Clinical Governance is also covered in the chapter on Patient Safety and Clinical Governance.

42. **Information Governance**. Information Governance provides the necessary safeguards for the disclosure, and appropriate use of, patient and personal information. Health Boards should be aware of the extent and limitations of their powers and act accordingly. Staff must be trained in the correct procedure for handling confidential patient information and should also be provided with procedures for obtaining guidance where they are unsure whether they should disclose information. Information Governance risks are also addressed in the chapter on Capacity to Deliver.

Scrutiny

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

44. **Internal Scrutiny**. Internal scrutiny of health boards is provided by non-executives, internal performance monitoring systems and the work of internal audit. One of the main aspects of the role of non-executive members of boards is to challenge and to hold executives to account. They must be provided with the necessary information to support effective challenge.

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

Links to other work

46. Local auditors will be carrying out review work during 2008/09 on boards' staff governance action plans. Audit Scotland reported on NHS recruitment of overseas staff in November 2007. Audit Scotland's consultation on its forward study programme includes potential reviews of the Role of Boards and People Management in the NHS. The Auditor General's report to Parliament on the 2006/07 audit of NHS Western Isles, which commented on the board's corporate governance arrangements, led to an inquiry by the Parliament's Audit Committee.

Key risks

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

Consultation

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

Risk management

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

Controls framework

- Failure to implement a robust control framework results in a breakdown in core business system processes and controls and, ultimately a failure to maintain service delivery. The board should be able to provide evidence that:
    - sound systems of performance management – covering financial and workforce issues, as well as service delivery - are in place to support good governance and to monitor progress against the targets set by SGHD
    - it carries out a review of the effectiveness of the systems of internal control which is used to support the Statement on Internal Control contained within the annual accounts
    - it has well documented and published anti-fraud measures and is committed to the National Fraud Initiative in Scotland
    - it has put in place clear plans to meet the requirements identified from any NHS QIS 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 in 2006, to review governance arrangements in CHPs. The findings from the self-assessment should be reviewed and an action plan of improvements developed. A joint risk register and arrangements for monitoring it should be in place. Partnership working issues are further addressed in the chapter on Effective Partnership Working.

Major Projects

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

Information Governance

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

Patient Safety and Clinical Governance

Background

48. Patient safety is a significant concern to patients, the public and the NHS. Research studies have found that one in ten patients in Scotland may experience an adverse event in hospital and half of these have been judged to be avoidable. *Better Health, Better Care* states that one of the priorities for the Scottish Government is to improve patient safety. The national HEAT target is to reduce MRSA rates by 30 per cent by 2010.

49. NHS QIS has lead responsibility for reviewing boards' performance in relation to patient safety, and for working with boards to improve patient safety. Audit Scotland and NHS QIS have a memorandum of understanding and are in the final stages of agreeing an operational protocol that aims to:

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

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

51. The SGHD set up the Scottish Patient Safety Alliance (SPSA) in 2007, bringing together the Scottish Government, NHS QIS, health boards and special boards, professional bodies, patient experts and other groups. The SPSA launched the Scottish Patient Safety Programme (SPSP) in 2007. NHS QIS coordinates the programme and aims to use evidence-based tools and techniques to:

- reduce healthcare associated infections (HAIs)
- reduce adverse surgical incidents
- reduce adverse drug events
- improve critical care outcomes
- improve care received on general wards
- improve the organisational and leadership culture on safety.

52. The SPSP has been implemented in all territorial boards and the Golden Jubilee National Hospital (GJNH). It builds on work in Tayside, Ayrshire and Arran and Dumfries and Galloway as part of the UK Safer Patients Initiative. The SPSP has been implemented in acute hospitals initially but will be rolled out to include community and primary care services. NHS boards and the GJNH are expected to have identified an executive lead and a SPSP manager and set up multidisciplinary teams to drive local improvements in five identified workstreams. Boards are expected to be working towards the overall aims and goals for the SPSP. They may have agreed a local action plan (which may be a stand-alone plan or integrated with other local plans) and have systems to measure improvements. Boards are not required to submit any plans to the SGHD or NHS QIS.

53. Boards are expected to submit information on progress against the national measures, with supporting narrative, to the Institute for Healthcare Improvement (NHS QIS' technical partner) on a monthly basis. This information is intended to be used by boards themselves as part of continuous improvement and is not reported publicly. The key focus of the SPSP is developing a safety culture in boards and promoting self-assessment and continuous improvement, rather than implementing national performance management arrangements. *Better Health, Better Care* states that by March 2010 improvements in patient safety in the NHS will include moving to 'a quality improvement and safety culture in our hospitals underpinned by the capability and capacity required to sustain this culture over the long term'.

54. **Controlled drugs** - New UK regulations on the management of controlled drugs came into place in Scotland in March 2007, following the Shipman review. The three key elements of the new regulations are: the appointment of Accountable Officers; cooperation between health bodies and other organisations in relation to controlled drugs; and new powers of entry and inspection. By July 2007, all NHS and special health boards were required to have identified an Accountable Officer. The Accountable Officer is responsible for a range of measures relating to monitoring the safe use and management of controlled drugs and taking appropriate action where necessary.

55. **Use of antibiotics** - Inappropriate use of antibiotics is linked with increased HAI resistance to antibiotics. Guidelines on Antimicrobial Prescribing Policy and Practice in Scotland were issued to boards in 2005. Further guidance was published in February 2008 in the Scottish Management of Antimicrobial Resistance Action Plan (ScotMarap). All boards are expected to have an antimicrobial management team that covers primary and acute care.

56. **HAI** - NHS QIS published updated HAI standards in March 2008 and will be carrying out reviews against these standards in 2009/10. A Health Department Letter issued in 2005 stated that all boards should have an infection control manager who is a board member or directly accountable to a board member. The infection control manager should have overall responsibility for management processes and risk assessment relating to all aspects of infection control. The HDL states that the scale of the role will mean that this should be a full time, or close to full time, role in most boards. The Infection

Control Manager is expected to report directly to the Chief Executive and the board, and be an integral member of the board's infection control, clinical governance and risk management committees.

57. **Clinical governance** - Patient safety is at the heart of clinical governance and risk management. NHS QIS published national standards for clinical governance and risk management in October 2005 and published its national overview of performance against the standards in October 2007. All boards received local reports following their own reviews. A further round of reviews will take place in 2009/10. One of the HEAT targets is that boards should show improvement against the clinical governance and risk management standards.

Links to other work

58. NHS QIS has responsibility for reviewing boards against the national clinical governance and risk management standards and the HAI standards, and for co-ordinating the SPSP.

59. Audit Scotland is reviewing national and local patient safety work in relation to use of medicines as part of a follow-up study to *A Scottish prescription: Managing the use of medicines in hospitals*. This is due to be published in early 2009.

Key risks

60. Auditors should review NHS QIS reports and meet with NHS QIS to discuss these key risks in the board. The key risks include:

Leadership and culture

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

Integration of patient safety into governance arrangements

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

Integrated planning

- Patient safety is not fully considered when planning, redesigning and providing services. The board should be able to demonstrate that:
    - patient safety, including ensuring best practice in preventing HAI, is considered and embedded in its Local Delivery Plan and in other strategies
    - the financial plans and budgets for new developments and changes to services build in the cost of patient safety requirements.

Continuous improvement

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

Communication and support

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

Financial Management and Affordability

Background

61. Investment in NHSS is increasing each year, from £9.4 billion spent in 2006/07 to £10.35 billion in 2007/08. In 2008/09, the level of investment is planned to be some £10.8 billion. However, it is unlikely that the level of increase experienced in recent years will be sustained in the longer term and the level of annual uplift has reduced from 6 per cent in 2007/08 to 3.15 per cent for 2008/09.

62. 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 with only one board reporting a cumulative deficit in 2007/08. But NHS boards continue to be concerned about future cost pressures and the related risks.

63. In its 2006/07 national overview report (December 2007), Audit Scotland noted that the financial performance of boards had improved with an overall underspend against the revenue budget. While boards are continuing to use non-recurring income to support their revenue position, this was not considered to represent a large financial risk across the service. But it remains an area of challenge for a number of boards.

64. The Scottish Government decides the level of funding provided to NHS boards and they are required to live within the funding levels provided. This means that boards need to make complex decisions on resource allocation as a result of a number of key challenges. These include the continuing shift in the balance of care to the primary care sector and the costs of funding new and continuing initiatives including the waiting times targets, many of which need to be financed from a tighter funding settlement. A key challenge is that the benefits from improving health (and therefore lower acute care costs) will take time to realise. Further challenges include equal pay; pay modernisation; rising drug costs; inflation and the current general downturn in the economy.

65. 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 *Better Health, Better Care* and its associated Action Plan
    - 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)
- 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.

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

- The Efficiency Programme will continue through the period covered by the 2007 spending review (2008-2011). This initiative aims to reduce waste, bureaucracy and duplication in the public sector. A target of 2 per cent has been set for efficiency savings across the public sector which may only be met by cash releasing gains. The NHSS is committed to achieving savings of £154.5 million across all NHS boards through a wide range of local efficiency projects including service redesign, workforce arrangements, estates and facilities and transport services. In addition, there are a number of national initiatives designed to generate savings in areas such as procurement and logistics.
- The impact of Equal Pay regulations has led to boards potentially facing significant costs relating to backdated pay increases. By the end of 2007/08, the NHSS Central Legal Office was again unable to provide any reliable estimate of each board's potential liability. The financial risks relating to this continuing uncertainty about potential liabilities need to be managed by boards.
- The NHSS Shared Support Services (SSS) Programme was relaunched during 2007/08 as a two tier initiative comprising:
    - a Foundation level, with all boards migrating to the same version of the Cedar eFinancials finance system during 2008 and achieving a minimum standard of business processes
    - Pathfinder initiatives where selected boards or consortia test new systems functionality and associated business processes, before roll out to other boards
    - Boards will need to consider the impact of SSS development on their financial plans and financial management resources.
- The NHSScotland Resource Allocation Committee (NRAC) was set up to review how the NHS budget is shared among the territorial health boards. It recommends improving the way the NHS budget is shared among health boards in Scotland. In total, compared to the existing Arbuthnott Formula, the proposed NRAC changes would redistribute £81.9 million among Health Boards – this represents 1.2 per cent of the overall budget and may have a substantial monetary impact on some health boards.

- The European Working Time Directive (EWTD) requires that the number of hours junior doctors will be permitted to spend on hospital wards will be reduced to 48 hours. Health boards will need to put into place an action plan to achieve this reduction in hours and manage the subsequent impact on costs.
- As part of the UK Budget 2007, the Chancellor announced that the timetable for International Financial Reporting Standards (IFRS) implementation was to be extended by a year with NHS and central government accounts in Scotland to become IFRS compliant with effect from the 2009/10 financial year. The Scottish Government has notified the appropriate bodies that they should produce shadow IFRS based accounts for the financial year in 2008/09, including a restated balance sheet as at 1 April 2008. This process may require significant resource to complete and it will be important that the restatement is tackled early in 2008/09, with a plan in place to manage the transition.

Links to other work

67. In 2007/08, as part of developments in the audit of Best Value, external auditors applied a Use of Resources Toolkit on Financial Management at most territorial health boards. Toolkits on asset management, procurement and efficiency are being developed for application in a future year.

68. Audit Scotland's *Overview of Scotland's Health and NHS Performance 2006/07* (December 2007) comments extensively on the financial position of boards and financial management in NHSS. This will be updated in the 2007/08 overview report which will be published in December 2008. It also published a report on day surgery in Scotland which highlighted that about £8 million of resources could be freed up if boards increased their same-day care performance (September 2008). Audit Scotland is also carrying out a review of asset management in the NHS, planned for publication in early 2009.

Key risks

69. 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 any 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 identified 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.
- While no board will have funding reduced as a consequence of the NRAC review, overall funding uplifts will be less for some boards than would have been the case under Arbuthnott. In addition, inflation may rise at a faster rate than the funding uplift. Boards should have robust plans in place to ensure they are able to match the demands of the service with the funding provided.

Integration of service and financial planning

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

Scrutiny and monitoring

- Inadequate financial information is available, impacting on management's ability to effectively monitor financial performance. The board should have an integrated financial system which is used to prepare effective and transparent budgets and subsequent reports on the financial impact of shared services, joint budgets and regional planning.
- Financial management processes do not include measurable outputs and the board is unable to demonstrate value for money from additional investment or changes in service delivery. The board should be able to show that it has specific output and outcome measures and that performance against them is regularly monitored.
- The board and its committees do not receive regular financial reports which allow them to effectively scrutinise and challenge the financial position and ensure Efficient Government targets are being met. Reports should include sufficient analysis of the financial performance of operating divisions and CHPs/CHCPs.
- There is a lack of financial expertise at board level to provide meaningful scrutiny. The board should be able to demonstrate that members have sufficient support and training.

Partnership working

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

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
    - it is making progress in achieving its planned savings.

Affordability and sustainability

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

Performance Management

Background

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

71. 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.

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

73. Boards are expected to monitor and report progress against other key targets and initiatives, including Efficient Government and pay modernisation.[3] The latter requires boards to submit benefits delivery plans and progress reports to the SGHD to demonstrate how they are using the new staff contracts to deliver benefits.

74. The Scottish Government is continuing to develop its approach to performance management based on a National Performance Framework and outcome agreements. The National Performance Framework is based on the outcome-based 'Virginia-style' model of performance measurement and reporting. In support of this, the Scottish Government has developed a new electronic tool and website (Scotland Performs) to communicate to the public on Scotland's progress. This will include progress on overall delivery of the administration's purpose for Government, the five strategic objectives for Scotland and other aspects of the outcomes based National Performance Framework.

75. There is an expectation that all public sector bodies, including the NHS, should be able to clearly demonstrate how their activities are aligned with the Government's overarching purpose through the National Performance Framework. Single Outcome Agreements (SOAs) have been established for local government for 2008/09. In 2009/10 these will be extended to cover Community Planning Partnerships (CPPs), although about half of the first phase of SOAs already include some wider actions for some CPPs. Boards, through CPPs, require to engage with local government to develop the SOAs and be part of collective responsibility to communities to deliver on outcomes.

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

Links to other work

76. As part of its programme of work on the audit of Best Value, Audit Scotland is developing a toolkit on performance management. This will be applied in a future year. Audit Scotland's *Overview of Scotland's Health and NHS Performance 2006/07* (December 2007) comments on performance against the HEAT targets.

Key risks

77. These include:

Embedded local performance management

- Performance management and reporting is not given sufficient priority at appropriate levels in board structures and the arrangements do not ensure that performance management leads to continuous improvement. Boards focus on national targets to the detriment of ensuring that they are delivering sustainable local services. The board should be able to demonstrate that:
    - performance management is an integral part of the board's strategic, operational, financial and patient-focused planning process and is clearly considered during service redesign projects
    - the performance management system leads to continuous improvement in service delivery e.g. by developing action plans following local or national reviews and following up action plans to ensure progress
    - the performance management system considers the economic, efficient and effective use of resources
    - performance management arrangements consider the quality of care i.e. outcome rather than output focussed
    - there is clear accountability and responsibility for delivery.

Core performance management principles

- The board's performance management systems do not incorporate recognised core principles of performance management. The board should be able to demonstrate that:
    - performance management, measurement and accountability systems cover the whole organisation, not simply areas covered by HEAT targets
    - performance management arrangements support full alignment with the National Performance Framework
    - the board provides an accurate and timely view of activity and outputs that supports progress to well-defined outcomes

- the board links input (finance and staff) to outputs (performance against targets) and quality of care
- benchmarking data is collated, shared and used appropriately
- there is regular review and discussion of this data at monthly (or more frequent) scrutiny meetings led by chairs and board members and/or by senior management, focussing on the data and actions to improve performance
- there is active follow-up of the actions identified from the data and the discussion.

Local Delivery Plan targets

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

Partnership working

- A joint performance management framework is not in place resulting in poor and untimely decision making. 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 NHS board should have procedures in place for ensuring that:
  - key performance measures have been identified, and defined, for areas of joint working and these are regularly monitored and reviewed
  - performance management reporting lines and timescales are clear
  - performance monitoring arrangements are sophisticated enough to provide evidence of improved service delivery as a result of partnership working, including through SOAs.

Efficient Government

- The board does not monitor 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. This should include demonstrating the link between time-releasing savings and increased performance against targets without the need for additional investment.

Public reporting

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

Capacity to Deliver

Background

78. NHSS is going through a period of substantial change as it responds to developments in healthcare, demographic movements, and political and administrative initiatives. This pattern of simultaneous pressures results in a particular challenge for boards – that of ensuring that it has the organisational capacity to address a whole range of developments, all of which are required for the successful delivery of NHSS's core objectives.

79. *Better Health, Better Care* is the core strategic change programme for NHSS. It recognises that efficiency improvements are necessary to achieve the goal of providing better access to local healthcare services, allowing the people of Scotland to sustain and improve their health and support the ethos that the people of Scotland and NHSS staff should be 'co-owners' of the service.

80. With an increased focus on flexible, local delivery, particularly in rural areas and areas of deprivation, it is clear that changes will be required in the way in which services are currently delivered in the NHS. Boards will have to reassess their priorities and current working practices to design local sustainable services which fulfil the government's requirements, secure best value and support local, frontline services, with key service change proposals being subject to independent scrutiny. Boards will therefore have to assess their ability to deliver on these key issues with reference to management, workforce, infrastructure, information management and financial capacity.

81. The NHS faces a number of key challenges:

- ensuring that there is sufficient management capacity to deliver the change agenda and deliver improved services successfully
- workforce planning should ensure that NHSS has the right staff in the right place at the right time in order to deliver high quality care and services to the people of Scotland. To achieve this, the workforce needs to be fully aligned with service delivery that is both affordable and sustainable
- the impact of major pay modernisation contracts and of Modernising Medical Careers will continue to affect boards, and the monitoring of doctors hours against the EWTD must continue
- equal pay claims lodged following on from the Equal Pay Act (2004) 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 has been created to help establish consistency in how equal pay claims are handled across Scotland

- as part of the Efficient Government programme, boards need to take action that will achieve the SGHD's key savings targets
- ensuring asset management strategies are regularly reviewed and that the infrastructure is in place to deliver the required services to the necessary standards.

82. The *eHealth Strategy 2008-2011*, published in June 2008, describes a number of significant information technology (IT) procurements and developments that will be required to support service redesign. Boards need to ensure that:
    - eHealth initiatives are fully integrated with clinical and service redesign programmes
    - arrangements are in place to guarantee that business continuity and contingency plans are developed, tested and reviewed
    - staff fully understand their duty to keep data confidential
    - they are able to demonstrate that they fully comply with all information assurance legislation.

83. Boards should have a robust financial management framework in place which includes short and long-term financial plans, savings targets, financial recovery plans, financial risk management, budget monitoring and financial scrutiny at all levels. This will ensure that boards have the financial capacity to deliver the required level of service. This is discussed further within the chapter on Financial Management and Affordability.

Links to other work

84. As part of developments in the audit of Best Value, Audit Scotland has developed a Use of Resources Toolkit on Information Governance which will be applied at health boards in 2008/09. A toolkit on People Management will be developed for application in a future year.

Key risks

85. These include:

Leadership and management capacity

- The board does not demonstrate the clear vision and leadership necessary to achieve the culture change required to deliver a positive change in health outcomes. The board should have developed and communicated a clear vision of the future which is outcome focussed, flexible and, if necessary, commit to stopping doing things that have not made the difference intended.

- Poor programme and project management results in late or inefficient and ineffective project delivery for key redesign projects. The board should have assessed its management capacity to deliver its vision and programmes of service improvement, including executive leadership, risk and change management, programme and project management requirements, and workforce requirements.

- Management capacity is insufficient to meet the requirements of planning and managing the change agenda, and implementing learning and training developments for staff. Involvement with managing change and implementing new contracts means that management time is taken away from the main task of delivering improved services. The board should be able to demonstrate that this has been considered at a local level.

Workforce capacity

- Workforce development strategies are not fully integrated into all service activities and planning at every level, i.e. 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 and is able to take forward an annual workforce plan and contribute to regional workforce plans as required
  - plans in place to develop nursing workforce planning in line with the requirements of the Chief Nursing Officer's letter of August 2007, *Implementation of Nursing and Midwifery WorkLoad and Workforce Planning Tools and Methodologies*
  - an established staff appraisal system which seeks to identify training and development needs, and has sufficient resources to meet these needs
  - joined up workforce plans with financial and service plans.

- Workforce information is not sufficiently robust or accurate to enable the construction of credible evidence-based decisions to support workforce management, including planning and development. This includes work in the development of team-working, delivery of care, skill mix and career development. The board should be able to demonstrate that:
  - data on workforce is sufficiently detailed and accurate to meet the requirements of workforce planning, SWISS, the Equality Act 2006 and the staff governance standard

- continues to monitor doctors' hours in accordance with the Modernising Medical Careers (MMC) and the European Working Time Directive
- contingency plans are in place to address any deficiency in workforce data.

- The board does not have procedures in place to assess and demonstrate how it is delivering the benefits of pay modernisation. The board should be able to demonstrate that:
  - it is actively using pay modernisation as one of the drivers for change
  - it is considering value for money as part of this process
  - it has procedures in place to enable them to produce Pay Modernisation Benefits Delivery Plan progress reports to the SGHD and to meet the requirements of HDL(2005)28.
- There is a risk that the board does not have plans to manage the risks of equal pay claims. The board should be able to demonstrate that it has identified the risk of possible equal pay claims, including those relating to potential age discrimination and has put in place plans to deal with such claims.
- There is no robust system in place to provide an accurate record of staff sickness absence. The board should be able to demonstrate that a system is in place to allow it to measure the success of initiatives designed to achieve the 4% staff sickness absence target by 31 March 2009.

Infrastructure capacity

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

Information management capacity

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

Further Information

Information relevant to all topics

- Partnership For Care, Scotland's Health White Paper, Scottish Executive, February 2003 - http://www.scotland.gov.uk/library5/health/pfcs.pdf
- Rebuilding our National Health Service, Guidance to NHS Chairs and Chief Executives for implementing Our National Health: A plan for action, a plan for change, Scottish Executive, May 2001 - http://www.show.scot.nhs.uk/sehd/onh/onh-00.htm
- Overview of Scotland's Health and NHS Performance, Audit Scotland, December 2007 - http://www.audit-scotland.gov.uk/docs/health/2007/nr_071214_nhs_overview.pdf
- Overview of the performance of the NHS in Scotland 2007/08, Audit Scotland (due to be published in December 2008)
- Building a Health Service Fit for the Future, Scottish Executive - A National Framework for Service Change – Advisory Group, May 2005, http://www.show.scot.nhs.uk/sehd/nationalframework/
- Delivering for Health, Scottish Executive, November 2005 - http://www.scotland.gov.uk/Publications/2005/11/02102635/26356
- Better Health, Better Care: A discussion document. Scottish Government, August 2007 – http://www.scotland.gov.uk/Publications/2007/08/13165824/0
- Better Health Better Care: Action Plan, Scottish Government, December 2007 http://www.scotland.gov.uk/Publications/2007/12/11103453/0
- Principles and Priorities: The Government's Programme for Scotland, Scottish Government, September 2007 - http://www.scotland.gov.uk/Publications/2007/09/05093403/0

Effective Partnership Working

- Community care and The Joint Future Unit http://www.scotland.gov.uk/Topics/Health/care
- CCD 7/2001 Joint Resourcing and Joint Management of Community Care Services, Scottish Executive, 5 September 2001- http://www.show.scot.nhs.uk/sehd/publications/ccd7-01.pdf

- Community Care and Health (Scotland) Act 2002- http://www.hmso.gov.uk/legislation/scotland/acts2002/20020005.htm

- Community Health Partnerships, Scottish Executive Health Department, 2006 http://www.show.scot.nhs.uk/sehd/chp/

- Developing services for older people – consultation on joint services framework for older people, Scottish Executive, July 2004 http://www.scotland.gov.uk/consultations/social/bofop.pdf

- National Health Service Reform (Scotland) Act 2004 http://www.scottish.parliament.uk/business/bills/pdfs/b06s2-stage2-amend.pdf

- Commissioning community care services for older people, Audit Scotland, 2004 http://www.audit-scotland.gov.uk/publications/pdf/2004/04pf08ag.pdf

- Adapting to the future. Management of community equipment and adaptations. A baseline report, Audit Scotland, August 2004 http://www.auditscotland.gov.uk/publications/pdf/2004/04pf09ags.pdf

- Single outcome agreements

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Scrutiny and Governance

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Glossary

Agenda for Change	A UK-wide new pay system for all NHS staff with the exception of doctors, dentists and most senior managers. The new system aims to standardise conditions of service for staff.
Annual review	Annual review of a board's performance against its key performance measures and targets, led by the Cabinet Secretary for Health and Wellbeing. The 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 (i.e., 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 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.
Financial balance	Where income received is equal to expenditure on an ongoing basis.
Governance	The framework of accountability to users, stakeholders, and the wider community in which the organisations take decisions, and lead and control their functions, to achieve their objectives.
Health, Equality, Access, Treatment (HEAT) targets	A range of key performance targets agreed between boards and the SGHD. Performance against these standards is reported with the board's annual operating and financial review and is discussed at the annual review.
Independent Sector Treatment Centre (ISTC)	These are private-sector owned treatment centres that are contracted within the NHSScotland. They perform common elective (i.e., 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.
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.
National Fraud Initiative (NFI)	A sophisticated data matching exercise which matches electronic data within and between participating bodies to prevent and detect fraud.

Private Finance Initiative (PFI)	The UK Government's initiative to encourage the development of private finance in the public sector.
Public Private Partnership (PPP)	A generic term for projects involving both the public and private sectors. The involvement can be to varying degrees and the partnership can take different forms. PFI is one example of PPP.
Revenue Resource Limit (RRL)	The amount of money an NHS Board is allocated to spend on day-to-day operations in any one financial year.
Scottish Futures Trust	The Scottish Futures Trust will develop the expertise and investment models for a range of public sector infrastructure projects including new schools, hospitals and transport infrastructure projects for Scotland.
Scottish Government Health Directorates (SGHD)	The SGHD (previously known as the SEHD) is responsible both for the NHS in Scotland and the development and implementation of health and community care policy. The SGHD oversees the work of the 14 territorial health boards and 9 special health boards.
Scottish Workforce Integrated Strategic System (SWISS)	This system aims to provide accurate and consistent information about the NHSScotland workforce.
Single Outcome Agreements (SOA)	Single Outcome Agreements are agreements between the Scottish Government and each council which set out how each will work in the future towards improving national outcomes for the local people in a way that reflects local circumstances and priorities.
Time-releasing savings	Efficiencies which do not release cash but allow frontline services to deliver more or better services with the same money. For example, through reducing sickness absence.
Virginia Model	A strategic planning and communications, outcomes-based performance model, used in the State of Virginia, USA.

Priorities and Risks Framework

A national planning tool for 2008/09 NHSScotland audits

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