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Northern Ireland Audit Office

General Report on the Health and Social Care Sector

REPORT BY THE COMPTROLLER AND AUDITOR GENERAL
18 December 2018

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This report has been prepared under Article 8 of the Audit (Northern Ireland) Order 1987 for presentation to the Northern Ireland Assembly in accordance with Article 11 of the Order.

K J Donnelly
Comptroller and Auditor General

Northern Ireland Audit Office
18 December 2018

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Abbreviations

A&E	Accident and Emergency
BAU	Business as Usual
BHSCT	Belfast Health and Social Care Trust
BSO	Business Services Organisation
BSTP	Business Service Transformation Programme
DEL	Departmental Expenditure Limit
DoF	Department of Finance
DoH	Department of Health
FPL	Finance, Procurement and Logistics
HMRC	Her Majesty's Revenue and Customs
HRPTS	Human Resources, Payroll, Travel and Subsistence
HSC	Health and Social Care
HSCB	Health and Social Care Board
ICP	Integrated Care Partnerships
KPIs	Key Performance Indicators
LCGs	Local Commissioning Groups
LNC	Local Negotiating Committee
NHSCT	Northern Health and Social Care Trust
NIAO	Northern Ireland Audit Office
NIAS	Northern Ireland Ambulance Service
NIFRS	Northern Ireland Fire and Rescue Service
OBC	Outline Business Case
OECD	Organisation for Economic Co-Operation and Development
PAC	Public Accounts Committee
PHA	Public Health Agency
PSSSP	Public Sector Shared Services Programme
RRL	Revenue Resource Limit
RSSC	Recruitment Shared Services Centre
RTM	Requirements Tracking Module
SEHSCT	South Eastern Health and Social Care Trust
SHSCT	Southern Health and Social Care Trust
UAT	User Acceptance Testing
WHSCT	Western Health and Social Care Trust
WLI	Waiting List Initiative

Executive Summary

Executive Summary

1. This latest Health General Report which covers 2015-16 and 2016-17 provides us with an opportunity to review recent developments across key areas within the local health and social care (HSC) sector:

   - the financial performance of the HSC Trusts;
   - timely access to hospital care and performance against waiting time targets;
   - the implementation of the Business Services Transformation Programme (BSTP); and
   - payments to consultants in line with the Waiting List Initiative.

2. Our work provided an insight into the range of significant challenges facing the HSC sector in delivering high standards of care to patients in a timely manner, in the context of growing demand for services, and within very tight financial constraints. Our key findings are summarised at paragraphs 3 to 15.

The Financial Performance of HSC Trusts

3. Since 1991, HSC bodies have been statutorily required to `break even' financially, by not spending more than the limits of their revenue and capital budgets. In line with this requirement, all five Trusts[1] recorded a surplus in 2015-16 and 2016-17, but since being established in 2007, the Trusts have accumulated a total cumulative deficit of just over £18 million.

4. Whilst appropriate in accounting terms, this current form of financial reporting does not accurately capture the underlying financial position and the pressures facing the Trusts. In practice, the Trusts have only been able to achieve surpluses through:

   - the Department of Health (DoH or the Department) implementing a series of annual non-recurrent efficiency savings across the health and social care budget;
   - the allocation of additional in-year monitoring funding to the DoH totalling £173 million in 2015-16 and 2016-17, to ease operational and financial pressures largely across Trusts, in the absence of which other savings would have been unavoidably implemented to ensure breakeven; and
   - demand significantly exceeding funded capacity, reflected in increasing waiting times.

5. Against this background, the HSC system continues to face mounting pressures, with costs of maintaining existing service models continuing to increase at a pace which cannot be sustained within available budgets. Consequently, difficult choices have to be made. In purely financial

1 This report focuses on the five main HSC Trusts (Belfast, Northern, South Eastern, Southern and Western).

terms, the Department estimates that the underlying pressure across Trusts at the start of 2017-18 was approximately £160 million, an increase of approximately £45 million from the estimated pressure of £115 million in 2014-15. The total HSC sector funding gap, which fully reflects inflationary and demographic pressures, the need to transform service delivery, and build capacity to meet population need, will be significantly higher.

6. We have advocated a twofold approach to address the challenges presented by this serious and rapidly escalating situation. Firstly, we have concluded that instead of the current annual arrangements, longer term financial planning and commissioning of services could help move Trusts away from 'firefighting' short term pressures, and assist them in developing longer-term and better value for money solutions. Allied to this, we have also underlined the importance of enhanced local health and social care needs assessments to provide a robust baseline for informing future commissioning and funding allocations.

Operational Performance – Timely Access to Hospital Care

7. Due to financial pressures, the HSC sector has been unable to meet the operational demands brought about by the increased demand for care, and as a result, waiting times have grown. Increased demand is being driven by many factors, including the increasing and older population, higher patient expectations, improvements in technology and a wider range of available procedures.

8. At the overall Northern Ireland level, none of the waiting time targets we examined for inpatient and outpatient care, accident and emergency treatment and cancer treatment were achieved in 2015-16 or 2016-17, even though the waiting time targets for inpatient and outpatient care were adjusted by being lowered, to take account of increased demands and the acknowledged capacity gap.

9. Furthermore, only part of the inpatient care target and each of the cancer targets were met at individual Trust level. The recent fall in waiting time performance against the 31 day cancer care target and further decline in performance against the 62 day cancer care target is concerning. Whilst there has been recent improvement in respect of the 14 day target for breast cancer referrals, the overall target has not been achieved. These outcomes come against a background of the total number of people being treated consistently increasing.

10. Trusts clearly do not have the capacity to continue meeting an increasing demand for services while delivering current standards of care and staying within budget. Therefore in the context of rising demand for care increasingly exceeding health service capacity and uncertainty over future funding, we have concluded that the Trusts will continue to struggle to meet future waiting time targets.

Executive Summary

The Business Services Transformation Programme (BSTP)

11. The Business Services Transformation Programme (BSTP) was aimed at introducing shared services across four service areas and 16 HSC user organisations. It was estimated that the introduction of BSTP would generate efficiency savings of almost £125 million over a 10-year period, a substantial portion of which would be achieved by the end of 2016-17.

12. However, during the implementation of BSTP, significant difficulties arose. These included a £10 million cost increase; significant delays in the implementation of the Human Resources, Payroll, Travel and Subsistence (HRPTS) system; and difficulties in correcting overpayments made to staff by the payroll system. One staff member was overpaid by more than £43,000 over three years.

13. In practice, the introduction of BSTP had achieved savings of £48.8 million at the end of 2016-17, and is currently projected to achieve savings of £99.4 million by 2021, compared to the anticipated £125 million. Given the experiences in implementing these systems, it is critical that the lessons learnt by the Business Services Organisation (BSO)[2] are more widely disseminated across the public sector for the delivery of future shared service projects.

Payments to consultants under the Waiting List Initiative

14. Given the scale of the gap between funded health service capacity and patient demand, Trusts have been allocated non-recurrent funding each year to undertake additional activity to reduce waiting lists. Trusts were expected to utilise the funding to maximise in-house capacity in the first instance by setting up additional evening and weekend clinics – commonly referred to as Waiting List Initiative (WLI) activity. Once in-house capacity had been fully maximised, Trusts secured additional capacity from independent sector healthcare providers. The additional non-recurrent funding provided was utilised to fund consultant payments (WLI payments) and pay private sector healthcare providers.

15. A review of payments made by the Southern Trust from April 2015 to March 2016 identified that the Trust had entered into an agreement with consultants which was based on the number of cases which the Trust expected to be completed during 4 hour in-house sessions. Whilst consultants were delivering all work allocated to them, some consultants completed the cases in less than the allocated 4 hours, and for those consultants the Trust was paying for working time of almost £247,000 which had no impact on waiting lists.

2 Business Services Organisation provides a broad range of regional business support functions and specialist professional services to the health and social care sector in Northern Ireland.

Overall Conclusions

16. Our review has highlighted the scale of future challenge facing the Department and Trusts in areas which are fundamental to delivering healthcare services to the local population in an effective and efficient way. The HSC system continues to be under mounting pressure and the costs associated with maintaining existing models of service continue to increase at a pace which cannot be sustained within the budget available.

17. There is a clear need for successful transformation of service delivery models which can help the system adapt to increasing patient demand and funding constraints. This vision is set out in Delivering Together[3], which describes a new service model that would see greater investment in prevention, early intervention and primary care, and reconfiguration of hospital and community services, appropriately resourced to deliver high quality care, with specialist acute services delivered from fewer sites. However the successful delivery of this vision will require new ways of working, including with partners outside of HSC Trusts.

3 *Health and Wellbeing 2026: Delivering Together,* Department of Health, October 2016.

Part One:
The Financial Performance of HSC Trusts

Part One:
The Financial Performance of HSC Trusts

At 2016-17, the five main HSC Trusts had accumulated deficits totalling over £18 million

1.1 Health and social care funding is the single largest area of public expenditure in Northern Ireland. In 2016-17, the total budget, was £4.9 billion, accounting for 46 per cent of the Executive's overall budget. Some £3.6 billion of this (73 per cent) was allocated to the Health and Social Care Board (HSC Board) and Public Health Agency (PHA) to commission services from the HSC Trusts (the Trusts)[4] and other bodies.

1.2 The current process for commissioning health and social care services in Northern Ireland is outlined at **Figure 1**.

Figure 1: Process for commissioning health and social care services in Northern Ireland

- The HSC Board and the PHA, are responsible for commissioning health and social care services, primarily from the five Trusts, who deliver the services to local populations, and also from the primary, community and voluntary sectors and Integrated Care Partnerships (ICP) care systems.
- The Department of Health (DoH or the Department) sets out its priorities and targets for health and social care in an annual *Commissioning Plan Direction*. The HSC Board (in collaboration with the PHA) is required to produce an annual Commissioning Plan in response. This plan establishes the services to be commissioned during a financial year and their associated costs.
- The HSC Board is assisted in preparing the plan by five Local Commissioning Groups (LCGs) who undertake a needs assessment of the local population based on relevant data and information sources. The Commissioning Plan also provides the basis on which each Trust prepares their individual plans for delivering the commissioned services.

Source: NIAO

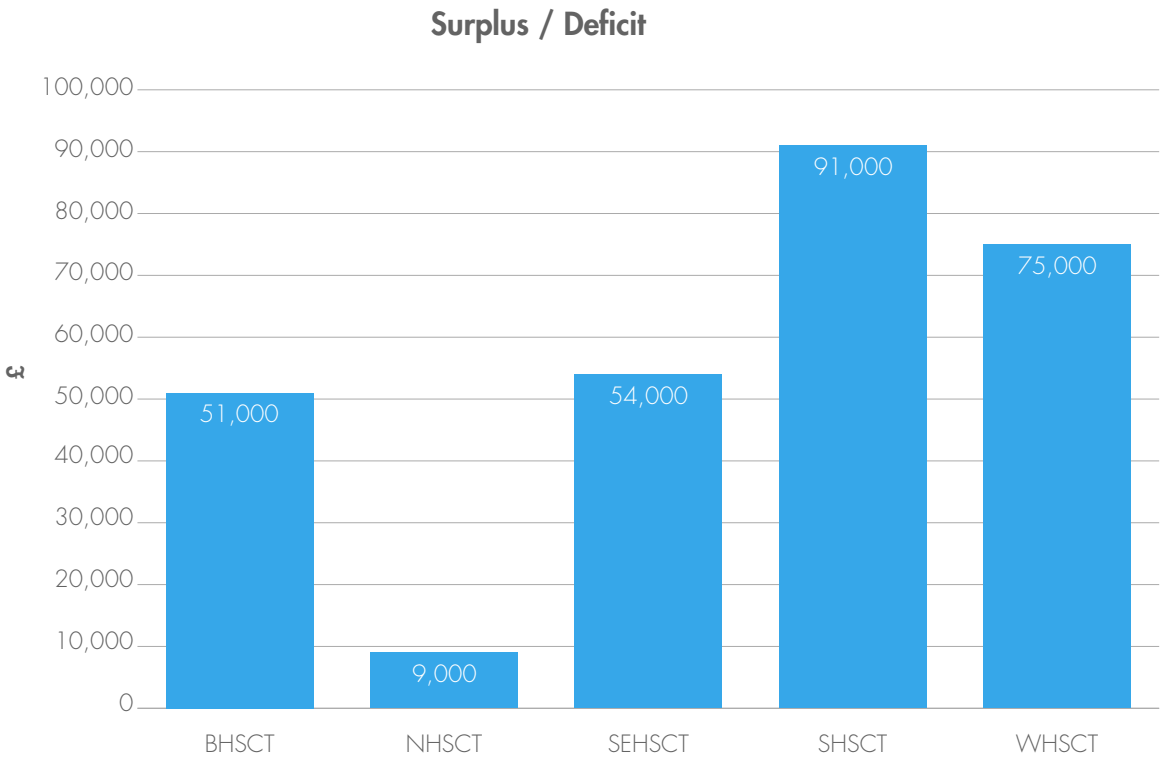
1.3 On completion of the commissioning process, the Department makes direct revenue allocations annually to the HSC Board and the PHA to cover health, community health and social care services through a Revenue Resource Limit (RRL). The HSC Board and PHA then issue monthly RRLs to the Trusts, which enables them to draw down money from the Department to cover their expenditure.

1.4 Since 2008, the Department has been required to identify and implement annual efficiency savings across the health service. These amounted to £164 million and £159 million in 2015-16 and 2016-17 (3.5 per cent and 3.3 per cent of the budget respectively). Additionally,

4 In addition to the Belfast, Northern, South Eastern, Southern and Western HSC Trusts, the Northern Ireland Ambulance Service Health and Social Care Trust (NIAS) provides an ambulance service across all of Northern Ireland.

HSC bodies have been statutorily required from 1991[5] to achieve a "break even" financial position at the end of each financial year, by not exceeding their revenue and capital budgets. Whilst the sector continued to face financial pressures in 2015-16 closely linked to a growing demand for services, 15 out of 16 HSC organisations, including the five main HSC Trusts, recorded a surplus in line with the break-even threshold, and all HSC bodies recorded a surplus in 2016-17. For the Trusts, this surplus was very marginal, ranging between £9,000 and £91,000, or between 0.001 per cent and 0.036 per cent of gross expenditure (**Figure 2**).

Figure 2: All Trusts reported a surplus position in 2016-17



Source: NIAO, based on HSC Trust data

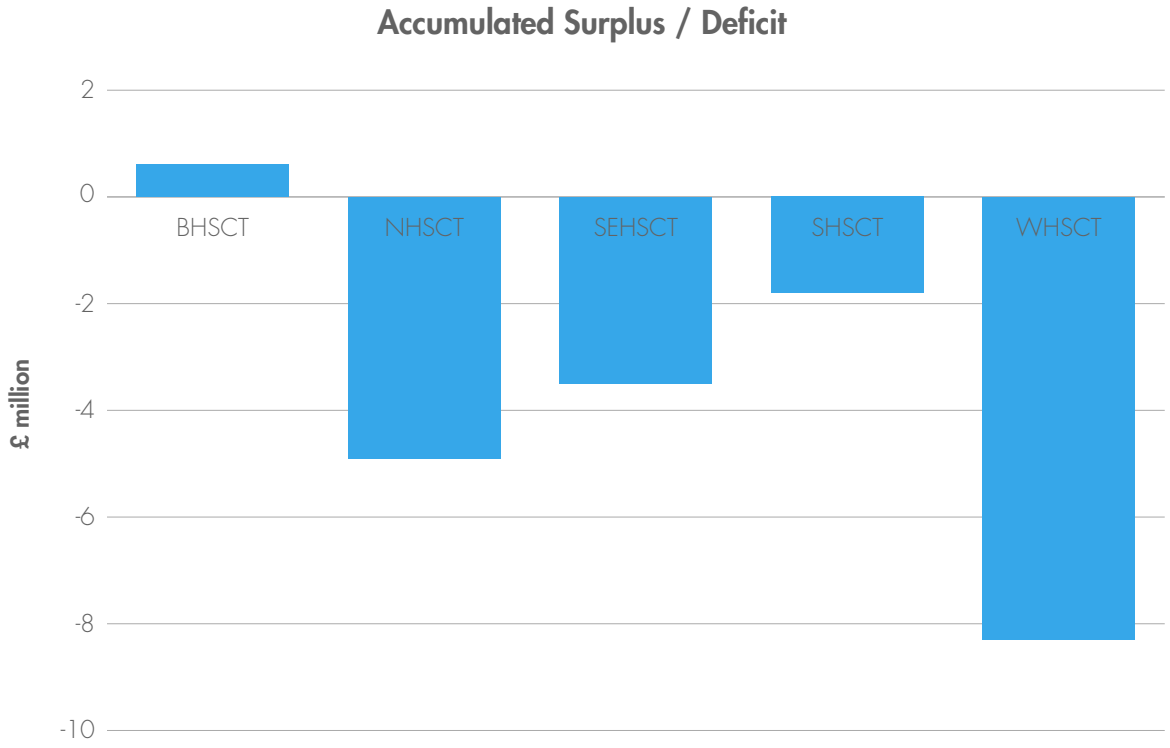
1.5 The accumulated deficit which has developed within the overall HSC sector[6] fell from £3.6 million in 2015-16 to £3 million in 2016-17. This is largely attributable to the HSC Board and the PHA having a combined accumulated surplus of £15.8 million. However, underlying this, the five main HSC Trusts continue to carry accumulated deficits totalling £18.2 million in 2016-17. This helps illustrate the particular financial pressures facing the Trusts (**Figure 3**).

5 Article 15 (1) The Health and Personal Social Services (Northern Ireland) Order 1991.

6 Including 16 Departmental Arms Length Bodies, but excluding the Northern Ireland Fire and Rescue Service (NIFRS).

Part One:
The Financial Performance of HSC Trusts

Figure 3: In 2016-17, Trusts reported total accumulated deficits of just over £18 million



Source: NIAO, based on HSC Trust data

The financial deficit across the HSC sector is at least £160 million, and could be significantly higher

1.6 Whilst appropriate in accounting terms, this form of reporting does not take account of other financial and operational pressures facing the Trusts. In practice, savings have had to be made to ensure the ongoing provision of services within the available funding and in the face of rising demand. The current reporting arrangements also mask operational pressures created by the requirement to 'break even'. Against this background, Trusts have only been achieving annual surpluses because:

- In 2015-16 and 2016-17, the HSC sector collectively received additional funding of £172.7 million from in-year monitoring rounds largely to help ease budget and operational pressures across Trusts. This funding has been increasing. For example, whilst £66.9 million was provided in 2012-13, £96.5 million was made available in 2016-17. The increased

reliance on in-year monitoring, whilst helpful in overall terms, mitigates against robust and more strategic management of the financial position, as it is often received late in the financial year; and

- In the context of increasing demand for services and budget restraints, Trusts have not had the capacity to meet key waiting time targets, and as Part 2 of this report points out, waiting time performance across the HSC sector has deteriorated significantly.

1.7 Moreover, the requirement to achieve savings, combined with rising demand means that, at the start of each financial year, Trusts are faced with a funding gap against the available budget to maintain existing services. This funding gap is increasing as the demand for care continues to rise each year, a visible impact of which can be seen in increasing waiting times.

1.8 This latest review highlights the significant funding gap between the Trusts break-even position and the increasing financial and operational pressures facing them. In purely financial terms, the Department estimates that the underlying pressures across Trusts at the start of 2017-18 was approximately £160 million, an increase of approximately £45 million from the estimated underlying pressure of £115 million at the start of 2014-15. The total HSC sector funding gap which fully reflects inflationary and demographic pressures, technological advances, the need to transform service delivery and build capacity to meet population need will be significantly higher. This demonstrates how Trusts require significant additional funding to treat their patients above the current allocations made through the HSC Board commissioning process.

1.9 Although the Trusts achieved a combination of both recurrent and non- recurrent savings in 2015-16 and 2016-17, the proportion of recurrent savings measures reduced from 52 per cent in 2015-16 to 34 per cent in 2016-17. Achieving savings on a non-recurrent basis provides a misleading impression of the Trusts' financial status. To achieve meaningful and long-term financial sustainability, Trusts need to make recurrent savings. Non-recurrent savings mean Trusts have to identify and implement additional savings each year in place of those made previously.

1.10 While the measures taken in 2015-16 and 2016-17 have assisted the Trusts in achieving financial break-even targets, many of these do not necessarily demonstrate increased productivity or efficiency. In our view, a tight financial position, together with an annual commissioning process, forces Trusts to address short-term pressures, rather than considering longer-term solutions which might ultimately represent better value for money

Part One:
The Financial Performance of HSC Trusts

A revised approach to assessing demand for care and commissioning services is needed

1.11 In contrast to the limited scope which annual commissioning offers for achieving more efficient outcomes, the healthcare sectors in Scotland and Wales now operate under a more medium term approach, with three-year plans and commissioning. When the Public Accounts Committee (PAC) examined this issue[7] in 2015, it recommended that the Department should consider introducing a similar flexible system to avoid the annual budgetary constraints and monitoring round bail-out arrangements which currently afflict Trusts.

1.12 PAC recommended that the Department of Health (DoH) approach the Department of Finance (DoF) (then the Department of Finance and Personnel), to explore available options for introducing three-year budgets for the Trusts. In response to DoH, DoF highlighted that the next budget round would extend across a three year period from 2017-2020 for Resource Departmental Expenditure Limit (DEL) and across four years for capital DEL. This may have empowered Trusts to plan more effectively. Whilst the Department has undertaken to continue discussions with DoF on this issue, it highlighted that the issue of budgetary allocations is ultimately a matter for the Executive. Under the current arrangements, the Secretary of State has set a one year budget for 2018-19. In the absence of certainty of funding to address future pressures, it has therefore not been possible to set a budget beyond one year for the Trusts.

1.13 The pressures apparent within the commissioning and provision of health and social care services also create fundamental challenges to transformation, which aims to deliver an increased role for community and preventative care. The Donaldson Review[8] which was published in December 2014 concluded that the current commissioning and budgeting structures are inappropriate for a system moving from acute hospital care to one based more on community and primary health care services.

1.14 In 2014, the Organisation for Economic Co-operation and Development (OECD) commenced a review of the commissioning and delivery of local health and social care services, publishing their report in July 2016. Emerging findings from this work were considered within the Department's Review of Commissioning, which was published in October 2015. Both the OECD report and the Review of Commissioning concluded that the current arrangements, whilst having some positive aspects, were not fit for purpose and did not provide a proper assessment of population health and social care need. Similar to the Donaldson Review, feedback to OECD from stakeholders involved in commissioning healthcare services highlighted a general absence of strategic thinking and a lack of capacity and expertise within the HSC Board to conduct a thorough needs assessment. Overall, the report considered that the HSC Board was inadequately equipped to allocate resources on a value for money basis. The Department subsequently consulted with stakeholders across the health and social care system on what changes should be made to the commissioning process. In March 2016, the then Minister

7 General Health Report and Social Care Sector (November 2015).

8 The Right Place, The Right Time (December 2014).

confirmed his intention to remodel HSC administrative structures, including the dissolution of the HSC Board and a move away from a system of commissioning.

Conclusions

It is essential that comprehensive population health and social care needs assessments provide a robust baseline for informing future funding allocations. Whilst local HSC needs assessments are currently carried out, these confirm that need is increasing in excess of available funding. This further emphasises the importance of substantial progress being achieved in implementing transformation.

1.15 Trusts clearly do not have the capacity to continue meeting an increasing demand for services while delivering current standards of care and staying within budget. *Delivering Together* provides an assessment of the challenges facing the HSC sector and proposes a way forward for delivering services which can help the system to deliver improved population health outcomes within the context of increasing patient demand. Work has commenced on this system-wide and long term transformation process, based on a partnership approach and aligned to overall financial planning processes. It is crucial that the Department strives to ensure that this work progresses in line with envisaged milestones and targets.

Recommendation

The Department, working closely with the Trusts and other providers and service users, should ensure that future changes to service delivery models as set out in Delivering Together are fully embedded to maximise patient outcomes, accountability and system sustainability.

Part Two:
Operational Performance – Timely Access to Hospital Care

Part Two:
Operational Performance – Timely Access to Hospital Care

Background

2.1 Each year, the Department issues to the HSC Board a *Commissioning Plan Direction* which defines the Minister's priorities and details specific standards and targets that should be delivered within the health and social care (HSC) sector. The introduction of targets aimed to provide a focus on improving performance, and reduce waiting times for patients. However, in recent years, HSC Trusts have found it increasingly difficult to meet most waiting time performance measures, despite the fact that inpatient and outpatient targets have been adjusted by being lowered to take account of increased demand and the acknowledged capacity gap.

2.2 Our last review[9] of Trust performance against waiting time targets for 2012-13 and 2013-14 found that:

- the number of inpatients and outpatients waiting longer than the maximum waiting times had increased in 2013-14 compared to 2012-13; and
- waiting time targets for emergency care and cancer treatment were not met in either 2012-13 or 2013-14.

2.3 At that time we concluded that **"***Hospital performance against waiting time targets has declined over the last two years. With the uncertain future financial position and the anticipated increase in demand on hospitals, HSC Trusts look set to struggle to achieve future targets"***.**

2.4 This latest review focuses on performance against four high-profile standards: Accident and Emergency (A&E) waits; referral for inpatient treatment; outpatient clinic waits; and cancer service waits. The report focuses on performance achieved in 2015-16 and 2016-17, but also includes performance achieved in 2014-15 for comparison purposes. Full details of the targets we reviewed are provided at **Figure 4**.

9 General Report on the Health and Social Care Sector 2012-13 and 2013-14 (May 2015).

Figure 4: The Department's key hospital waiting time targets 2014-15 to 2016-17

Area of provision	2014-15	2015-16	2016-17
Inpatient	At least **80 per cent** of inpatients and day cases treated **within 13 weeks** and no patient waits **longer than 26 weeks**.	At least **65 per cent** of inpatients and day cases treated **within 13 weeks** and no patient waits **longer than 26 weeks**.	**55 per cent** of patients should wait **no longer than 13 weeks** for inpatient / day case treatment and no patient waits **longer than 52 weeks**.
Outpatient	At least **80 per cent** of patients wait **no longer than nine weeks** for their first outpatient appointment and no patient waits longer than **15 weeks**.	At least **60 per cent** of patients wait **no longer than nine weeks** for their first outpatient appointment and no patient waits longer than **18 weeks**.	**50 per cent** of patients should wait **no longer than nine weeks** for an outpatient appointment and no patient waits no longer than **52 weeks**.
Accident and Emergency	**95 per cent** of patients attending any Type 1, 2 or 3 Emergency Departments are either treated and discharged home, or admitted, **within four hours** of their arrival in the Department. No patient attending any Emergency Department should **wait longer than 12 hours**.	**No change**.	**No change**.

Part Two:
Operational Performance – Timely Access to Hospital Care

Area of provision	2014-15	2015-16	2016-17
Cancer	**All** urgent breast cancer referrals should be seen within **14 days**. At least **98 per cent** of patients diagnosed with cancer should receive their first definitive treatment within **31 days** of a decision to treat. At least **95 per cent** of patients urgently referred with a suspected cancer should begin their first definitive treatment within **62 days**.	**No change.**	**No change.**

Source: Department of Health

Several factors are contributing to the significant increase in waiting times

2.5 There are a number of contextual issues which impact on the ability to deliver healthcare services within the waiting time targets set for the HSC sector by the Department (**Figure 5**).

Figure 5: Issues which impact on Trusts' ability to meet waiting time targets

Issue	Supporting Evidence
In recent years, limited additional funding has been made available to Trusts to specifically tackle waiting time performance, and when funding was provided, it was allocated late in the financial year, limiting the Trusts' ability to make best use of it.	Both inpatient and outpatient waiting times have been rising sharply since the middle of 2014-15, when funding ceased to be available for additional elective activity. Of the £40 million allocated in the November 2015 monitoring round, £21.5 million was utilised on additional waiting list activity, together with a further £3.4 million the Department was able to allocate. The inability to fully utilise the £40 million allocated in November 2015 was due to the funding being made available late in the financial year. An additional £30 million for 2016-17 was announced before the start of the year, to ensure progress in addressing waiting times. The Department made £7 million of additional funding available to Trusts in December 2017 to help ease pressure on the HSC sector. However, commitment of this funding was again made available late in the financial year.
Services commissioned by the HSCB on behalf of the Trusts have been insufficient to meet rising patient demand.	The Elective Care Plan, published in February 2017 identified that regionally in 2016-17, a gap existed between funded HSC capacity and patient demand of approximately: 63,000 new outpatient assessments; 34,500 inpatient/daycase procedures;[10] and 172,000 diagnostic tests[11]. By 2020-21, this was forecast to increase to approximately: 83,000 new outpatient assessments; 39,000 inpatient/daycase procedures; and 300,000 diagnostic tests.

10 Elective care is planned or scheduled patient care.

11 These figures exclude cardiac surgery, cardiology and endoscopy procedures.

Part Two:
Operational Performance – Timely Access to Hospital Care

Issue	Supporting Evidence
Increased demand for A&E services has contributed to longer waiting times: • delays in discharging patients often arise due to difficulties with securing social care packages; and • increases in emergency admissions can also reduce capacity for elective surgery and increase waiting times in this area.	Between 2012-13 and 2016-17, attendance at local A&E departments increased by 13 per cent compared to 8 per cent in England, 5 per cent in Wales and 1 per cent in Scotland in the same period. Furthermore, local attendances at A&E increased by nearly 34,000 between 2015-16 and 2016-17 alone. Between 2015-16 and 2016-17, the number of patients with immediately life threatening, very urgent or urgent conditions also increased by 25,000 (6.2 per cent).

Source: NIAO

Since 2014-15, inpatient and outpatient targets have been adjusted by being lowered to take account of increased demand and the acknowledged capacity

2.6 As **Figure 4** highlighted, the performance required to meet both elements of the key inpatient and outpatient targets have been adjusted by being considerably lowered since 2014-15 to take account of increased demand and acknowledged capacity. The Department told us that targets to reduce elective waiting times are reviewed annually to ensure they remain challenging and realistic, and take into account the number of people waiting to be seen and the resources expected to be made available to the HSC sector in that year. It stated that the significant change to the backstop to 52 weeks reflected the deterioration in waiting times from the second half of 2014-15 when additional non-recurrent funding ceased for waiting list initiatives.

None of the waiting time targets were met in any year at Northern Ireland level

2.7 For Northern Ireland overall, none of the key waiting time targets we examined were achieved in any year between 2014-15 and 2016-17 (**Figure 6**).

Figure 6: Overall performance against key hospital waiting time targets 2014-15 to 2016-17

Standard	Achieved 2014-15[12]	Achieved 2015-16	Achieved 2016-17
13 week inpatient target	x	x	x
52 week inpatient target	n/a	n/a	x
9 week outpatient target	x	x	x
52 week outpatient target	n/a	n/a	x
A&E 4 hour target	x	x	x
A&E 12 hour target	x	x	x
Breast Cancer 14 day target	x	x	x
Cancer 31 day target	x	x	x
Cancer 62 day target	x	x	x

Source: NIAO, based on Departmental and HSC Trust performance data

2.8 Paragraphs 2.9 to 2.23 examine in greater detail overall performance against the individual targets as well as how each Trust performed.

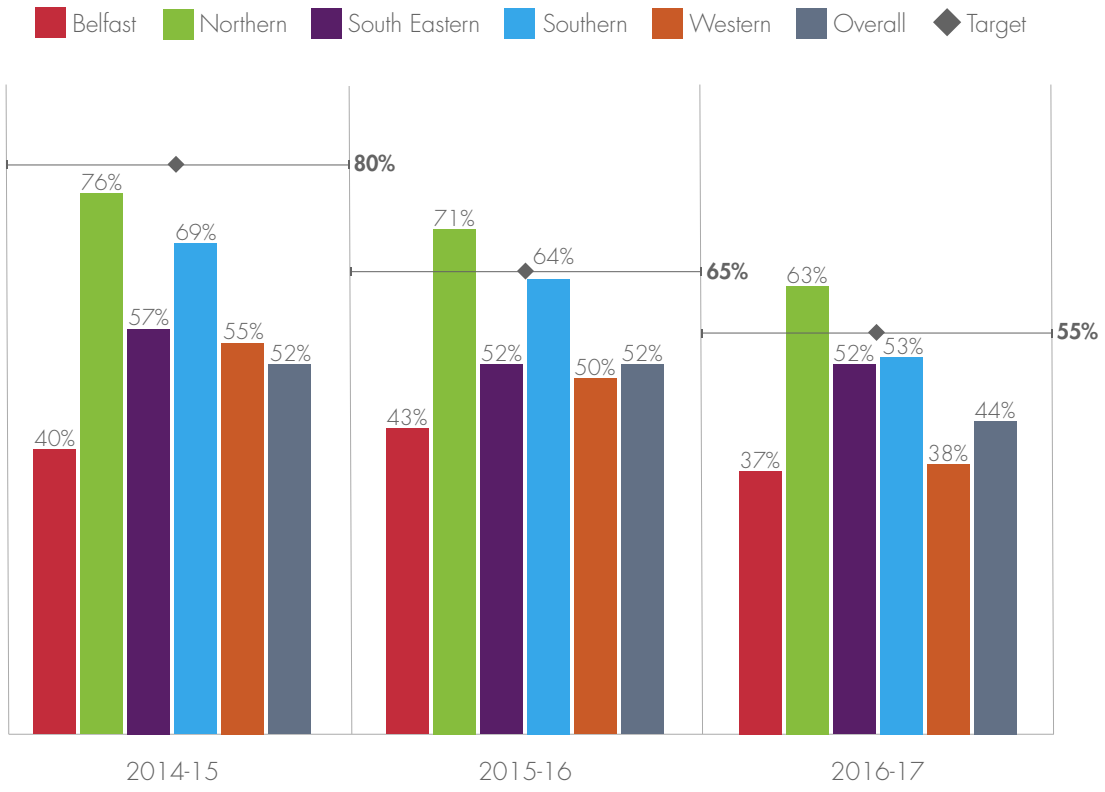
Inpatient waiting targets were not achieved overall, and only the Northern Trust achieved the 13 week target in any year

2.9 At a Northern Ireland level, the primary inpatient waiting target, which measured the percentage of patients treated within 13 weeks, was not achieved in any year (**Figure 7**). This was despite the target being reduced from 80 per cent in 2014-15; to 65 per cent in 2015-16; and again to 55 per cent in 2016-17. Furthermore, the percentage of patients waiting less than 13 weeks for inpatient treatment also fell by 8 per cent between March 2016 and March 2017.

12 The primary focus of this review was 2015-16 and 2016-17, but performance for 2014-15 is shown for comparative purposes.

Part Two:
Operational Performance – Timely Access to Hospital Care

Figure 7: Performance against the 13 week inpatient target has declined in all Trust areas since 2015



Source: HSC Trust data

2.10 In 2014-15, no individual Trust achieved the 80 per cent target. When the waiting target was reduced to 65 per cent in 2015-16, it was achieved by the Northern Trust (71 per cent), and was almost met by the Southern Trust (64 per cent). In 2016-17, only the Northern Trust achieved the 55 per cent target, but its performance fell from 71 per cent to 63 per cent. The Belfast Trust has performed below the levels of other Trusts.

2.11 No Trust achieved the target's secondary element, which required that no one should wait longer than 26 weeks for inpatient treatment in 2015-16, and 52 weeks in 2016-17. Between March 2015 and March 2016, the total number of patients waiting longer than 26 weeks for inpatient care increased from 13,600 to 17,600, and, at March 2017, over 9,600 patients had waited longer than 52 weeks (**Figure 8**).

Figure 8: Nearly 25,000 patients were waiting longer than 26 weeks for inpatient treatment at March 2017

Trust	Number of patients waiting longer than 26 weeks (March 2015)	Number of patients waiting longer than 26 weeks (March 2016)	Number of patients waiting longer than 26 weeks (March 2017)	Number of patients waiting longer than 52 weeks (March 2017)
Belfast	8,631	9,303	11,906	4,505
Northern	329	728	948	101
South Eastern	1,380	2,634	2,258	959
Southern	1,162	1,427	3,035	1,028
Western	2,120	3,509	6,406	3,022
Overall	**13,622**	**17,601**	**24,553**	**9,615**

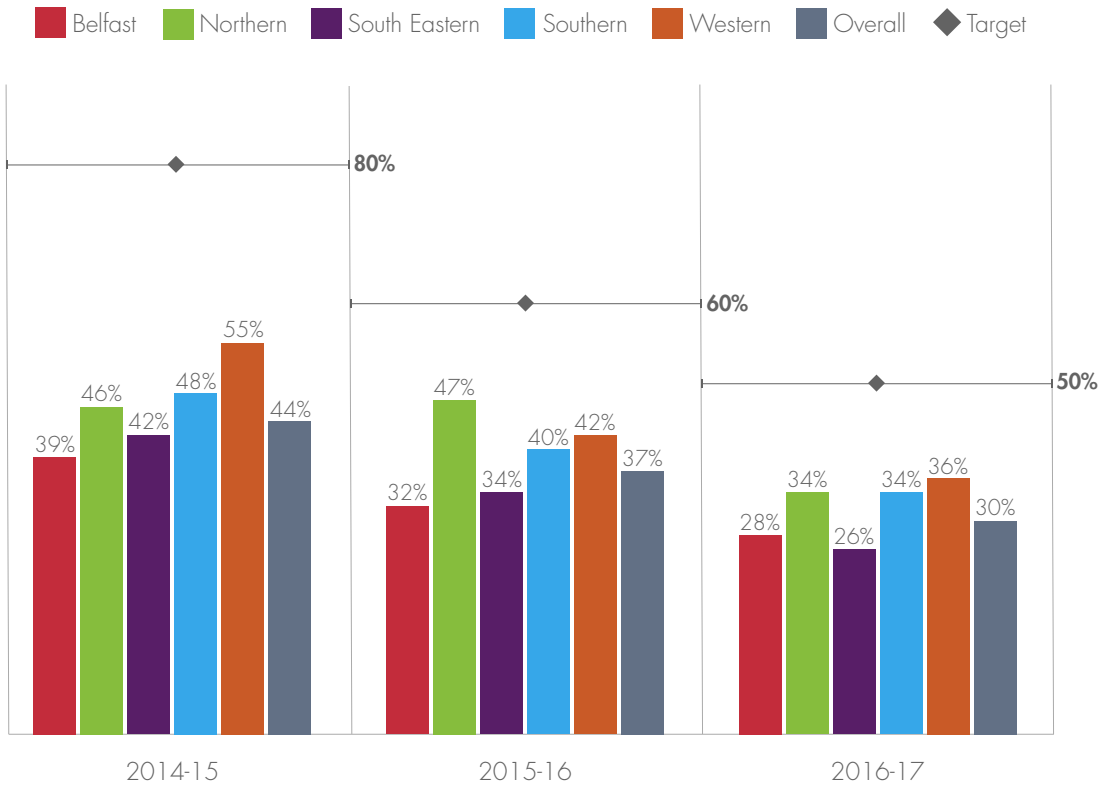
Source: HSC Trust data

Outpatient targets were not achieved

2.12 Performance against the main outpatient target, which required that a defined percentage of patients should wait no more than nine weeks for an appointment, is detailed at **Figure 9**.

Part Two:
Operational Performance – Timely Access to Hospital Care

Figure 9: Since 2015, performance against the nine week outpatient target has slipped in all Trusts



Source: HSC Trust data

2.13 Although the target was significantly lowered from 80 per cent in 2014-15, to 60 per cent in 2015-16, and to 50 per cent in 2016-17, it was not achieved in any year, either overall, or by any individual Trust. Overall performance also declined from 44 per cent to 30 per cent between 2014-15 and 2016-17.

2.14 Under the target's secondary element, no one was expected to wait longer than 15 weeks for an outpatient appointment in 2014-15, before this was increased to 18 weeks in 2015-16, and to 52 weeks in 2016-17. Again, this target was not achieved in any year, and substantial numbers of patients waited longer than the maximum period at all Trusts. Performance dipped between March 2015, when 82,000 patients had waited longer than 15 weeks, and March 2016, when 100,000 patients had waited more than 18 weeks. At March 2017, over 53,000 patients had waited longer than 52 weeks **(Figure 10**).

Figure 10: At March 2017, more than 53,000 people were waiting longer than 52 weeks for an outpatient appointment

Trust	No of patients waiting longer than 15 weeks (March 2015)	No of patients waiting longer than 18 weeks (March 2016)	No of patients waiting longer than 18 weeks (March 2017)	No of patients waiting longer than 52 weeks (March 2017)
Belfast	38,649	47,065	57,703	27,957
Northern	10,268	8,371	15,927	3,391
South Eastern	15,510	20,330	32,406	10,014
Southern	10,847	13,363	20,072	5,347
Western	7,212	11,106	15,740	6,404
Overall	**82,486**	**100,235**	**141,848**	**53,113**

Source: HSC Trust data

Accident and Emergency waiting targets were not achieved overall, or by any Trust

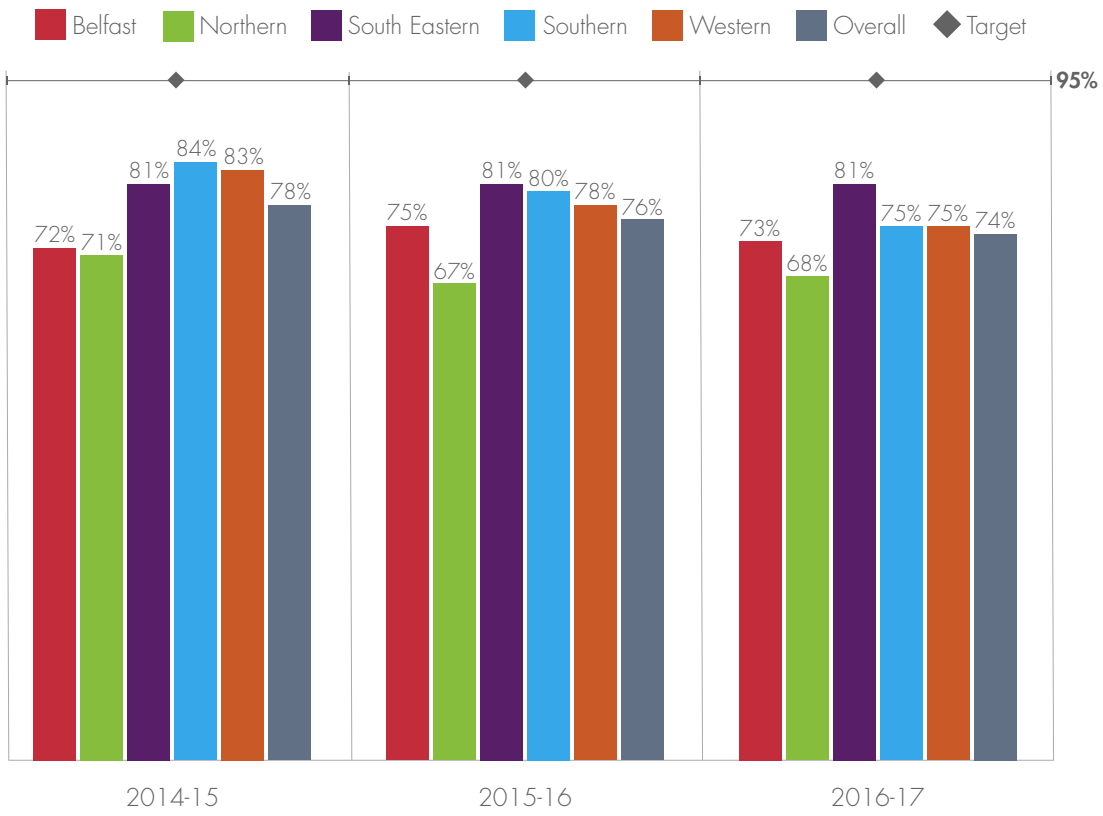
2.15 Between 2014-15 and 2016-17, the two key emergency care targets required that:

- 95 per cent of patients attending emergency departments were either treated and discharged home, or admitted within four hours of their arrival; and
- no patient attending any emergency department should wait longer than 12 hours.

Performance against these targets is shown at **Figures 11 and 12**.

Part Two:
Operational Performance – Timely Access to Hospital Care

Figure 11: Since 2015, no Trust achieved the four hour emergency care waiting target



Source: HSC Trust data

Figure 12: Significant numbers of people waited longer than 12 hours for emergency care between 2014-15 and 2016-17

Trust	2014-15	2015-16	2016-17
Belfast	1,756	917	1,714
Northern	663	1,087	1,893
South Eastern	713	1,606	1,478
Southern	14	93	910
Western	24	172	499
Overall	**3,170**	**3,875**	**6,494**

Source: HSC Trust data

2.16 Neither Accident and Emergency target was achieved in any year, either overall, or by any Trust. In 2015-16 and 2016-17, over 10,300 patients waited 12 hours or longer for treatment (84 per cent of which were in the Belfast, Northern and South Eastern Trusts). Aside from the South Eastern Trust, performance against the 12 hour target deteriorated significantly across all Trusts in 2016-17. It is important to recognise that performance in this area can be significantly influenced by rising levels of demand for A&E care. High and rising demand for A&E care therefore needs to be considered within the process for commissioning health and social care services.

Conclusions

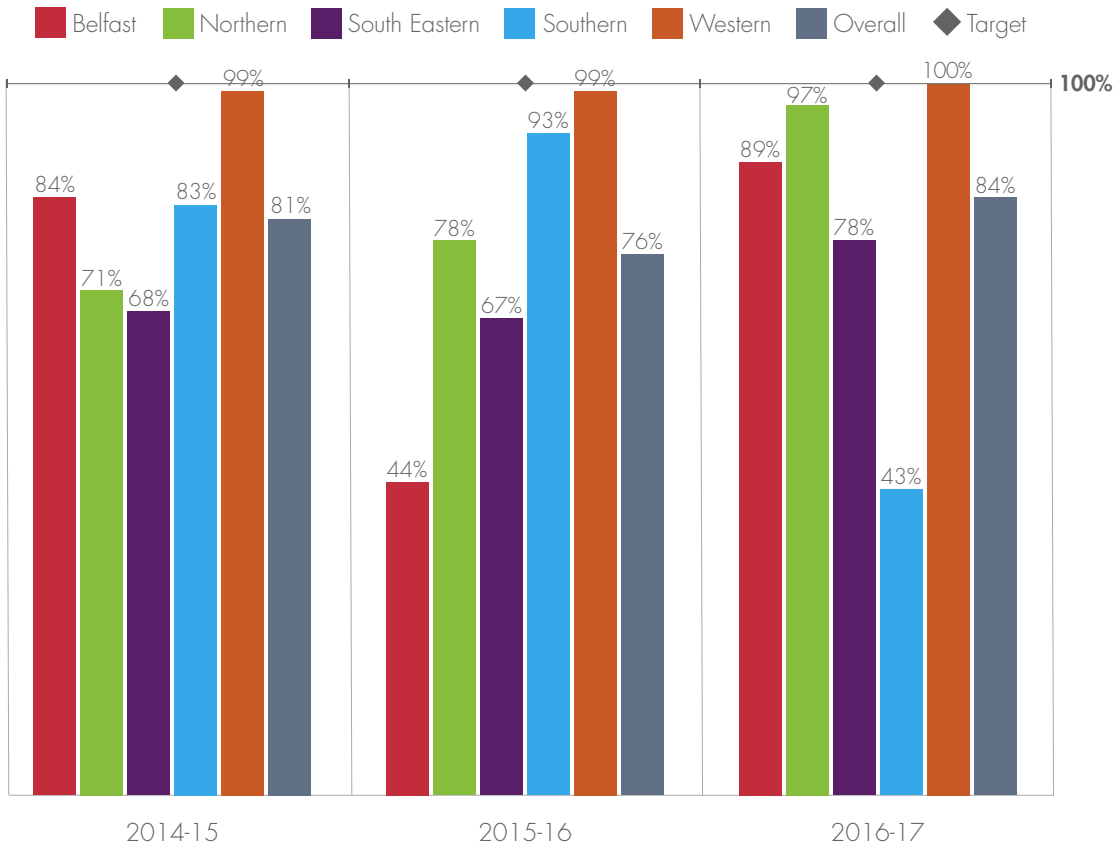
The deterioration in performance against waiting times for A&E care should be viewed in the context of increasing demand for such services. Against a background of finite resources, it is crucial that the HSC sector continues to utilise its detailed understanding of the relative influences of the causes of pressures on A&E, to help inform it of the steps necessary to mitigate these. Without such evidence, and supporting finance to help cope with the increased demand for A&E services, there will almost certainly continue to be a small proportion of patients spending more than 12 hours in A&E before they can be discharged home or admitted.

None of the three key cancer waiting time targets were achieved at Northern Ireland level

2.17 Under the key breast cancer waiting time target, all urgent referrals were required to be seen within 14 days. Performance achieved is shown at **Figure 13**.

Part Two:
Operational Performance – Timely Access to Hospital Care

Figure 13: Most Trusts did not meet the 14 day breast cancer waiting target



Source: HSC Trust data

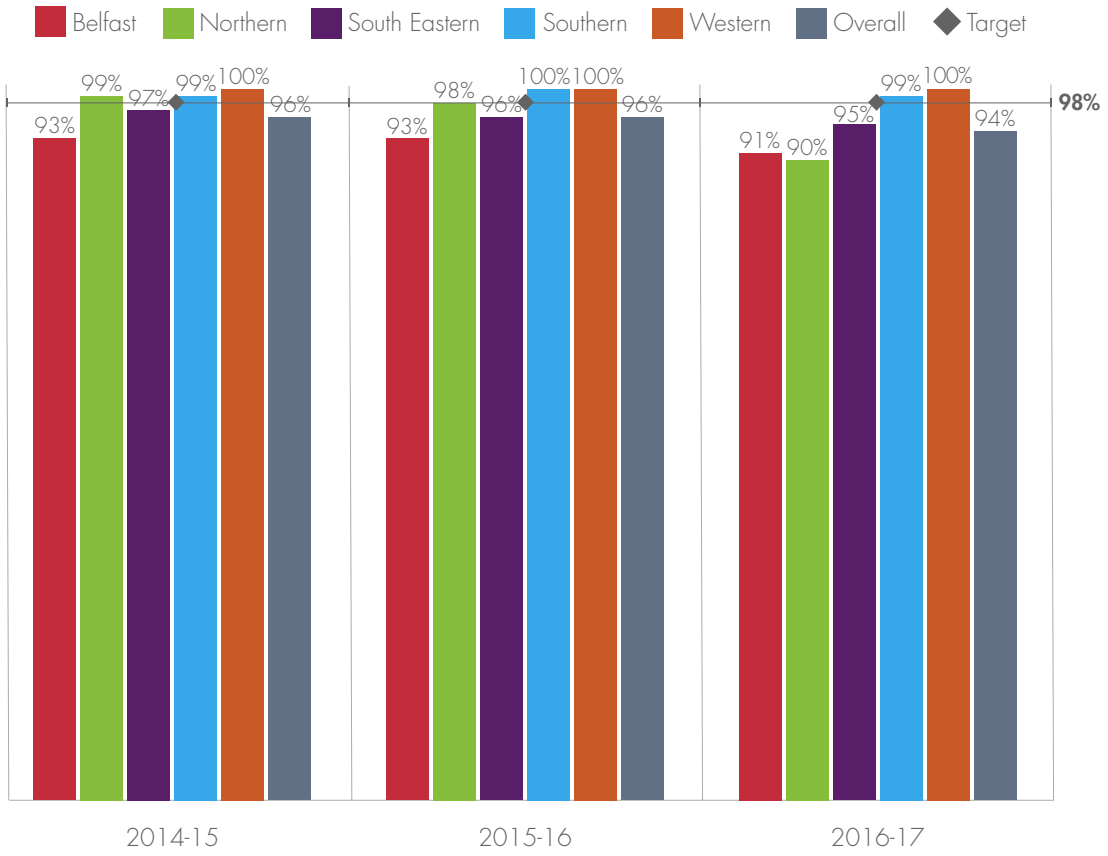
2.18 Again, the overall Northern Ireland target was not achieved in any year. At individual Trust level:

- the Western Trust performed best, almost meeting the target in 2015-16, and being the only Trust to actually achieve it in 2016-17; and
- the other Trusts consistently failed to meet the target, with performance in 2015-16 and 2016-17 ranging from 44 per cent to 89 per cent (Belfast), 78 per cent to 97 per cent (Northern), 67 per cent to 78 per cent (South Eastern), and 93 per cent to 43 per cent (Southern)[13].

2.19 **Figure 14** shows performance for the target requiring that at least 98 per cent of patients diagnosed with cancer should receive their first definitive treatment within 31 days.

13 It is important to acknowledge that on occasions, Trusts can work flexibly to address waiting time pressures and treat patients from other Trust areas, which can have the effect of increasing their own waiting time performance.

Figure 14: A number of Trusts met or almost met the 31 day cancer treatment target



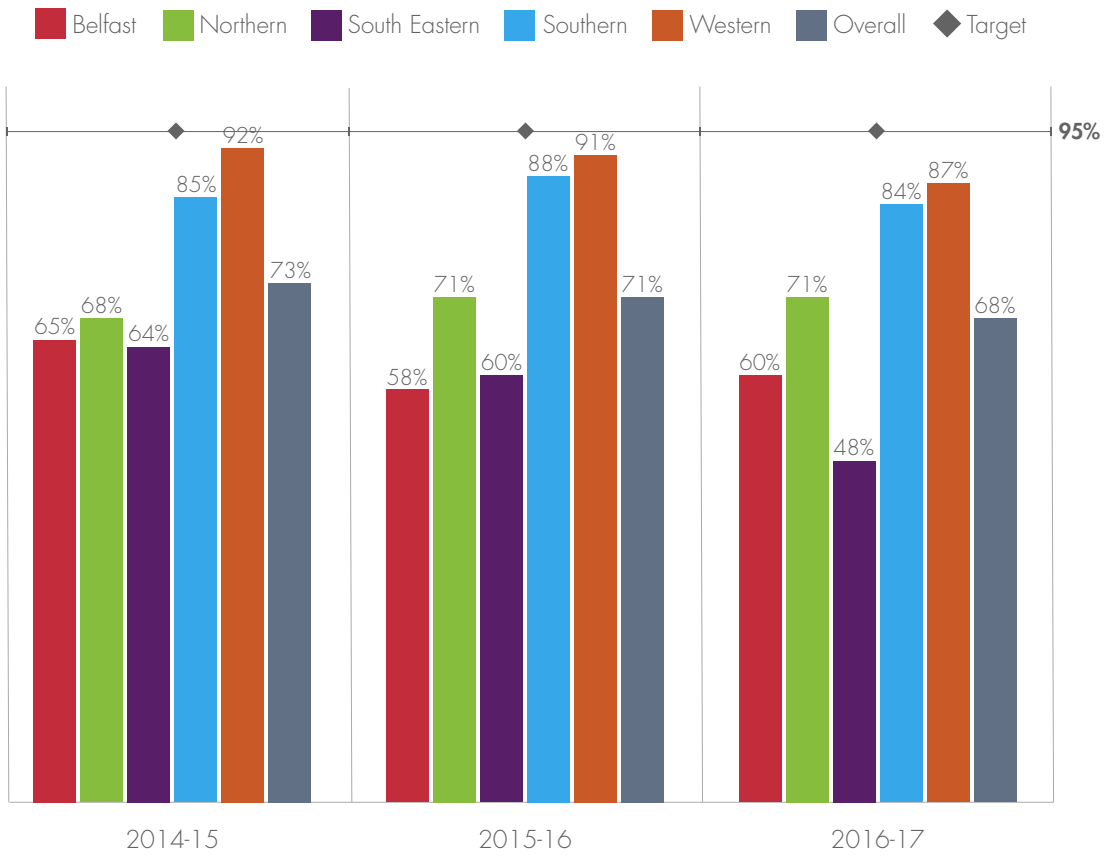
Source: HSC Trust data

2.20 Although the target was not achieved in 2015-16 or 2016-17 at Northern Ireland level, the Western and Southern Trusts met it in both years, and the Northern Trust achieved it in 2015-16, before its performance declined significantly in 2016-17. The target was not met in either year by the Belfast and South Eastern Trusts.

2.21 The third key cancer target sought to ensure that that at least 95 per cent of patients urgently referred with a suspected cancer should begin their first definitive treatment within 62 days. As **Figure 15** shows, no Trust achieved the target in either 2015-16 or 2016-17.

Part Two:
Operational Performance – Timely Access to Hospital Care

Figure 15: No Trust achieved the 62 day cancer treatment



Source: HSC Trust data

2.22 Despite the failure to meet the 31 or 62 day cancer targets, the Department told us that, according to the most recently available statistics for patients who were diagnosed with cancer between 2006 and 2010, there has been an improvement in five year net survival for almost all cancers, when compared with patients diagnosed between 1993 and 2000. This has increased from 38.3 per cent to 53.1 per cent for men, and from 48 per cent to 56.4 per cent for women. Notwithstanding this, early treatment is key to enhancing survival prospects of cancer patients, and any improved performance against the current waiting time targets would therefore be a welcome development.

2.23 Currently, the Department highlighted that the HSC Board and the PHA are working with Trusts to ensure that people with suspected cancer are seen, assessed and treated as soon as possible. It pointed out that it had allocated an additional £30 million in 2018-19 to help address waiting lists through targeting those patients with the highest clinical priority, including those with suspected or confirmed cancer.

Individual Trusts have only achieved a small proportion of the key waiting time targets, and will struggle to meet future targets

2.24 The key waiting time targets were only achieved by the individual Trusts on a small number of occasions. In summary:

- the Belfast and South Eastern Trusts did not achieve any of the targets in either year;
- no Trust achieved any of the outpatient and accident and emergency targets, or the 62 day cancer treatment target in either year;
- the 13 week inpatient target was only achieved by the Northern Trust, which met it in both 2015-16 and 2016-17;
- the 31 day cancer treatment target was achieved in both 2015-16 and 2016-17 by the Southern and Western Trusts, and in 2015-16 by the Northern Trust; and
- the 14 day breast cancer target was only achieved in 2016-17 by the Western Trust. No Trust met the target in 2015-16.

Overall conclusions

Since we last reported on 2012-13 and 2013-14, performance in respect of key waiting time targets has clearly been very disappointing. It is particularly concerning that targets for inpatient and outpatient care are still not being met, despite having been significantly reduced from 2014-15. This highlights the degree to which patients have been experiencing significant delays in securing access to treatment in these areas.

Going forward, we can only conclude that the rising demand for HSC services which is increasingly exceeding health service capacity, together with ongoing uncertainty over future funding, will significantly impact on the ability of HSC Trusts to meet future population need.

Part Three:
The Business Services Transformation Programme (BSTP)

Part Three:
The Business Services Transformation Programme (BSTP)

Overview

3.1 In February 2010, the Department approved an Outline Business Case (OBC) for a £28 million Business Services Transformation Programme (BSTP) to be overseen by the Business Services Organisation (BSO). This represented a significant investment in business systems to support a range of corporate services for Health and Social Care (HSC) bodies in Northern Ireland. Its purpose was to replace corporate support systems across the HSC sector, such as payroll, and introduce a shared service which would later become the responsibility of the BSO.

3.2 BSTP was aimed at introducing shared services across four substantial service areas and 16 user organisations. It involved three separate elements:

- procurement and implementation of a Finance, Procurement, and Logistics (FPL) ICT system;
- procurement and implementation of a Human Resources, Payroll, Travel and Subsistence (HRPTS) ICT system; and
- introduction of shared services to operate these new systems.

3.3 The programme aimed to allow greater standardisation and automation of processes and practices across the HSC sector, realising the full benefits of modern information technology and standardised efficient business processes, and ultimately sought *"to deliver economic and qualitative benefits in order to release resources to frontline care and enhance management in HSC."*

3.4 It was estimated that the introduction of BSTP would generate efficiency savings of almost £125 million over a 10-year period, a substantial portion of which would be achieved by the end of 2016-17. This would be achieved in particular through reduced procurement and operational costs whilst improving service quality, governance and accountability.

3.5 However, during the implementation of BSTP, significant operational difficulties arose which have been acknowledged by the BSTP Board and the BSO. Work undertaken by BSO Internal Audit, together with NI Gateway Reviews[14] completed throughout the implementation of the programme, was crucial in identifying key issues which needed to be addressed. Particularly significant issues were identified with the HRPTS ICT system and the related shared services, particularly for the Payroll and Recruitment functions. This report considers these issues.

14 The NI Gateway Review process is a series of independent peer reviews at key stages of a programme or project lifecycle, aimed at ensuring its successful delivery.

Increased costs of the BSTP

3.6 The February 2010 OBC had estimated total programme costs as being £28.3 million. In October 2011, goods and services were procured from two separate suppliers with contracts totalling £15.5 million. Soon after work had commenced on FPL and HRPTS, significant implementation difficulties arose in both. These included increased costs, missed implementation targets, unforeseen requirements, performance and stability issues and specification changes.

3.7 A review of the programme's financial position in May 2013 showed that there were insufficient funds available to complete it as planned, with total estimated costs having risen to almost £38 million. The additional £10 million of funding required to deliver the project represented a 35 per cent increase above the limit originally approved in the OBC. Costs currently stand at £37.2 million, with a further £547,000 of funding set aside for related initiatives up to 2020-21.

Human Resources, Payroll, Travel and Subsistence System

3.8 Over 70 per cent of the increased costs (£7.3 million) have resulted from extensive issues with implementation of the HRPTS element of the project. The Addendum to the OBC stated that delays in user acceptance testing, inadequate functionality and changes to core functionality were contributing factors to the delays and cost increases.

3.9 Due to the significant impact of these issues, the BSTP Programme Board considered a number of options for HRPTS in December 2012, including early closure of the project, but ultimately decided to proceed with it, subject to a substantial re-plan. The need to include additional functions[15] within the re-designed project resulted in further significant delays. Implementation for one Trust planned for May 2013 was delayed because critical interfaces between the HRPTS and FPL systems failed and because other functionality required, such as the ability to pay HMRC, was not complete.

3.10 Overall, there was a 16 month delay in the implementation of the HRPTS system, from November 2012 to March 2014. The issues arising and delayed go-live had a significant impact on the subsequent delivery of the other Trust go-live dates, including Payroll and Recruitment Shared Services, and on the overall costs incurred on delivering BSTP.

15 These functions included Multiple Employment and Real Time information.

Part Three:
The Business Services Transformation Programme (BSTP)

Payroll ICT system and shared service issues

3.11 A payroll shared services centre, which manages the payroll functions of all HSC bodies was established in 2014. However, it has subsequently experienced a range of operational and system issues and a contingency arrangement to pay staff has had to be used on four occasions. To address these issues, BSO initiated a separate payroll improvement project in May 2017. In examining this area in March 2017, Internal Audit provided:

- an Unacceptable assurance rating (the lowest possible), for the controls surrounding the payroll system and function stability (this has subsequently been amended to limited assurance in the March 2018 audit), and
- a Limited rating to payroll processing.

3.12 In its follow up review of payroll, Internal Audit highlighted the following issues:

- **Interfaces and security** - System interfaces were a major issue in both the implementation and ongoing use of HRPTS. Once interfaces were written and tested as functioning further new requirements arose. In the meantime the need for considerable manual intervention to transfer payroll data files increased the risk of error, fraud and data security issues. Internal Audit also reported that the level of segregation of duties was inadequate, with some users having up to 17 roles across the payroll module. Other security issues included administrator functions not being restricted and the superuser[16] role not being locked down to prevent unauthorised access.
- **Overpayments and inaccurate payments** - There were significant issues around the identification, correction, management and reporting of overpayments. Overpayments have occurred for various reasons, including failure by line managers to notify information on a timely basis, inadequate checking in some areas, and issues with the ICT system. In 2015 and 2016, Internal Audit found substantial error rates in their review of maternity pay calculations. Concerns have also been identified with the accuracy of employer superannuation contributions and national insurance contributions calculations. Overpayments identified included:
  - an employee being overpaid by more than £43,000 over three financial years.
  - an employee who was on a career break being overpaid by more than £13,000.

16 A superuser is able to log into an ICT system with privilege levels far beyond those of most user accounts.

We asked BSO for details of the number and value of payroll overpayments identified since the system was implemented and the proportion of these recovered to date. BSO told us that prior to April 2017 information on the number of overpayments was not centrally reported, but that it had identified 3,195 new overpayments in 2017-18 (approximately 0.27 per cent of payments made from the payroll system in that year). Since April 2017 monthly information is provided to all HSC bodies on numbers and value of overpayments, and the subsequent loans to staff created to recover these, although loans can be created for a variety of reasons. At the end of 2017-18 approximately £4 million of loans were outstanding, and an average of £320,000 had been recovered each month.

- **Stability** – Two major system changes, implemented during October and November 2016, resulted in significant system performance issues. This led to contingency arrangements being invoked to pay approximately 13,000 weekly and fortnightly staff. Whilst Internal Audit subsequently found that these plans were implemented successfully and all staff were paid, we consider that more robust testing prior to these major changes going live may have prevented the need to instigate contingency arrangements.

Recruitment system and shared service issues

3.13 The recruitment system and the associated shared service was implemented in April 2015. However, a Gateway Review of the BSTP undertaken in March 2016 concluded that *"there are significant issues with the recruitment system and shared service… The system is regarded by many as counter intuitive, not attractive to applicants, lacking in Key Performance Indicators (KPIs) and management information, with slower processing from initial request to appointment, and perceived by some to be worse than some of the previous systems."*

3.14 Several HSC bodies linked difficulties with recruitment to the implementation of the new ICT system and shared service, which may have impacted on the delivery of front line services. BSO told us that their subsequent analysis and assessment of recruitment information has highlighted workforce availability rather than recruitment processes as a major determining factor in this area. Other weaknesses identified include:

- inadequate performance and management information; and
- a lack of understanding as to how the entire recruitment and selection end-to-end process would operate within the new system, which may have impacted on the achievement of anticipated financial savings.

Part Three:
The Business Services Transformation Programme (BSTP)

3.15 In assessing Recruitment Shared Services in 2015-16, Internal Audit provided an Unacceptable assurance rating. This was subsequently upgraded to Limited assurance for 2016-17, and to a satisfactory rating in 2017-18. However, Internal Audit noted that of the eight KPIs for the service, five were still not being achieved as at August 2017. Achievement of the KPIs is dependent on a variety of processes, not all of which are owned by the recruitment and selection shared services centre, for example the completion of shortlisting and effective workforce planning.

3.16 We asked BSO whether all of the issues identified by this report had been subsequently resolved or whether action plans were in place to address any outstanding issues. BSO told us that the Recruitment Shared Services Centre (RSSC) is conducting an ongoing internal review of process flows and work alignment using management information from the Recruitment Administration system to flex resources to meet the peaks and troughs in service demand. In addition the RSSC is working collaboratively with colleagues across the HSC sector to drive up performance through streamlining process arrangements, developing attraction strategies to enlarge the applicant pool and deploying approaches to recruitment which seek to have a suitable pool available as early as possible in anticipation of need. The journey to service improvement is being managed both internally through robust management arrangements and through regional collaboration across the HSC sector. To address the ongoing issues within payroll shared services, a payroll improvement project is in place, which reports regularly to a Customer Assurance Board. In their March 2018 report, Internal Audit reported improvements within some of the key areas such as identification and reporting of overpayments, reflected in the movement from unacceptable to limited assessment.

Conclusion

3.17 This was an ambitious programme, striving to deliver new systems and shared services across a number of different organisations, and involving complex processes. We fully endorse the objective of securing efficiencies from the automation of corporate support processes and the use of shared services, to release resources for frontline care.

3.18 BSO informed us that financial benefits of £49 million had been delivered by 2016-17, against the estimated £124.8 million in the OBC Addendum. The BSTP Programme Board projects that total benefits of £99.4 million will be realised by 2021, leaving a £25.4 million shortfall. With capital costs of £37.9 million, this is still projected to represent substantial savings to the public sector. BSO also told us that emerging findings from the Public Sector Shared Services Programme (PSSSP)[17] reinforce external benchmarking information which indicates that BSO currently offers cost-effective provision of shared services for Human Resources & Payroll; Finance and Information Technology. However major issues clearly arose during the programmes

17 The PSSSP was established to take forward the NI Executive's commitment to the extension of shared services. It has a vision of collaboratively optimising shared services to enable excellent public sector delivery and covers health, education and central government sectors.

implementation and financial savings not realised are resources which could otherwise have funded frontline care. Positively, the Business Systems Forum has been tasked with monitoring benefits realisation and working to reduce the benefits shortfall.

3.19 It is critical that the lessons learnt by BSO, examples of which are outlined in **Appendix 1**, are incorporated into future projects as the sector moves towards shared services in other areas and are more widely disseminated across the public sector, particularly in light of the PSSSP. Lessons learnt from the BSTP also need to be taken into account within ongoing development of the PSSSP.

Part Four:
Payments to consultants under the Waiting List Initiative

Part Four:
Payments to consultants under the Waiting List Initiative

Background

4.1 Waiting List Initiative (WLI) payments aim to reduce waiting lists in Northern Ireland by providing extra funding to enable hospitals to set up additional clinics during evenings and weekends. These monies are then used to fund consultant payments or pay for private sector healthcare providers.

4.2 A media review of all WLI payments identified that the Southern Trust had the highest WLI earners in Northern Ireland, including one consultant who was in the top five UK national list of highest earners. As a direct result the Trust conducted its own review of the payments made from April 2015 to March 2016 and then engaged Internal Audit to carry out a more detailed examination of the payments. The main finding was that the Trust had not allocated enough work. Payments were made for extra-contractual work and targeted specifically at patients waiting longer than the target times in selected specialties. The Trust entered into a WLI that would pay consultants for this additional work based on a pre-agreed set amount of work within an average four hour session. The audit concluded that in some cases the Trust was not allocating enough work to fill a four hour session. When Internal Audit looked at the minimum and maximum activity levels suggested by appropriate benchmarks, it found that the amount of work being assigned to the consultants was broadly in line with the minimum activity levels expected and around half of the maximum expected.

4.3 The Trust immediately developed an action plan to address the issues, and all of the actions have been implemented. Internal audit will review this during 2018-19.

Findings

4.4 Internal Audit examined payments made to eight consultants who were the highest earners from WLI work in the Trust. They found that:

- payments were made to a number of consultants to help reduce waiting lists. This additional work was based on four hour sessions with an agreed amount of work allocated to them which was expected to take on average four hours.
- whilst consultants were delivering all work allocated to them, in several instances the Trust had allocated insufficient work to be completed during the four hour sessions.
- for six of the eight consultants examined Internal Audit found their work was being completed between 1.84 hours and 3.44 hours, therefore below the four hour allocation.

- Internal Audit compared the work completed within each WLI session with the minimum and maximum expectations included in professional guidance. Whilst the work within each session was generally in line with the minimum activity levels, it was approximately half of the maximum expected. However within one area the work was significantly less than the minimum expectations.

- whilst six of the eight consultants were paid for 3,856 hours (964 WLI sessions), the Trust only received 2,162 productive hours. This resulted in 1,694 hours at a cost of £247,000 being paid where the Trust received no impact on waiting lists.

4.5 In response to this, the Trust told NIAO that in identifying the 'appropriate' level of activity to be delivered in a four hour session, management had made reference to a paper produced by the Health and Social Care Board (HSCB) some years earlier. This document looked at productivity over a normal working week taking account of the range of interruptions typical in the normal working environment but not evident in a protected WLI session.

4.6 The Trust is currently strengthening the WLI agreement in conjunction with their Local Negotiating Committee (LNC). This document will include learning from the recent audit and subsequent discussions and will be circulated to all staff and managers. The Trust has now confirmed that it is satisfied that corrective action is already in place.

Appendix

Appendix
Examples of lessons learnt outlined in the BSTP Closure Report

- Where possible a single supplier should be used to reduce the complexity of works required.
- Withdrawal of renowned suppliers should be assessed to confirm that the requirements of the programme are achievable within resource and timescale.
- The specification used for procurement should be expanded to incorporate the business process that will be used with new systems. These should then be used to design, test and confirm delivery.
- Timescales for a programme should be realistic with strong links between objectives, deliverables and ultimately the benefits of the programme emphasised.
- Projects should be broken down into manageable components. However, where dependencies occur they should be planned and agreed between both parties. Links to other projects need to be factored into implementation plans.
- Financial reporting should be performed against the project plan rather than the fiscal year. Spend to date should be monitored against total funding available and the stage of the project.
- Where integration is required the extent of dependencies should be assessed in full to allow all risks to be captured and assessed.
- Client based knowledge should be integrated into the project as soon as possible to aid in planning and delivery.
- The deliverables should be prioritised to allow the project team and the supplier to best plan the order in which to implement project elements. A RTM[18] should be used to ensure that agreed deliverables are tracked.
- Experienced UAT[19] testers with system knowledge should be used.
- Processes and procedures should be developed prior to implementation. These should be adopted by all parties. Processes should be designed with the end goal in mind, where possible, rather than the current implementation.
- When a project has distinct stages a post implementation review should be performed after each stage to capture key information on benefits realisation and lessons learned.
- In terms of benefits realisation, future projects should consider:
  - creating a baseline at the beginning of the project;
  - aligning the objectives and deliverables to the benefits of the business case;

18 Requirements Tracking Module

19 User Acceptance Testing

  - establishing the benefit realisation for each project milestone;
  - monitoring the benefits at each milestone point; and
  - reviewing the benefits to confirm that they remain achievable, if necessary updating the business case for benefit values and timescales.
- The method of transition to BAU[20] as well as structures should be considered as part of project closure.

NIAO Reports 2017 and 2018

Title	Date Published
2017	
Continuous improvement arrangements in policing	04 April 2017
Management of the Transforming Your Care Reform Programme	11 April 2017
Special Educational Needs	27 June 2017
Local Government Auditor's Report	05 July 2017
Managing Children who Offend	06 July 2017
Access to Finance for Small and Medium-sized Enterprises (SME's) in Northern Ireland	26 September 2017
Managing the Risk of Bribery and Corruption: A Good Practice Guide for the Northern Ireland Public Sector	14 November 2017
Homelessness in Northern Ireland	21 November 2017
Managing the Central Government Office Estate	30 November 2017
2018	
Continuous improvement arrangements in policing	27 February 2018
Type 2 Diabetes Prevention and Care	06 March 2018
Financial Auditing and Reporting: General Report by the Comptroller and Auditor General for Northern Ireland – 2017	13 March 2018
Speeding up justice: avoidable delay in the criminal justice system	27 March 2018
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Local Government Auditor's Report – 2018	04 September 2018
The Financial Health of Schools	16 October 2018
Firearms Licensing in Northern Ireland (website only)	27 September 2018
The UK Border: How prepared is Northern Ireland for exiting the EU? (website only)	26 October 2018
The Social Investment Fund	08 November 2018
Eradicating Bovine TB in Northern Ireland	27 November 2018

Published and printed by CDS

CDS 205418

ISBN 978-1-912653-11-9