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Northern Ireland Audit Office

General Report on the Health and Social Care Sector by the Comptroller and Auditor General for Northern Ireland – 2010 & 2011

REPORT BY THE COMPTROLLER AND AUDITOR GENERAL
6 December 2011

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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 that Order.

K J Donnelly
Comptroller and Auditor General

Northern Ireland Audit Office
6 December 2011

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Abbreviations

BSO	Business Services Organisation
C&AG	Comptroller and Auditor General
C Difficile	Clostridium Difficile
CMO	Chief Medical Officer
CoPE	Centre of Procurement Expertise
CRL	Capital Resource Limit
CRU	Compensation Recovery Unit
CSR	Comprehensive Spending Review
DHSSPS	Department of Health, Social Services and Public Safety
DFP	Department of Finance and Personnel
GP	General Practitioner
HSC	Health and Social Care
ICO	Information Commissioner's Office
ICT	Information and Communication Technology
NDPB	Non-Departmental Public Body
NHS	National Health Service
NIAO	Northern Ireland Audit Office
NIAS	Northern Ireland Ambulance Service HSC Trust
PAC	Public Accounts Committee
PaLS	Procurement and Logistics Service
PCC	Patient and Client Council
PEDU	Performance, Efficiency and Delivery Unit
PHA	Public Health Agency
PPE	Post Project Evaluation
RPA	Review of Public Administration
RPCEG	Regional Pharmaceutical Contracting Executive Group
RQIA	Regulation and Quality Improvement Authority
STA	Single Tender Action

Section 1:
Introduction

Section 1: Introduction

Background

1.1.1 In June 2010 the Comptroller and Auditor General for Northern Ireland (C&AG) published the third General Report on the Health and Social Care (HSC) Sector looking principally at the results of the audits of the 2008-09 accounts.

1.1.2 This report focuses on the results of both 2009-10 and 2010-11 and also looks back at progress on issues raised since 2007-08. As has been the case in previous general health reports, both the financial and operational performance in the HSC sector has been considered, with the latter examined in more detail this time. Other areas of the report examine ongoing health service initiatives, some of the challenges facing the sector and procurement issues.

The scope of the audit and this report

1.2.1 The report covers the audits of 16 health bodies. These include the health and social care trusts[1] (the trusts), three special agencies established by the Department of Health, Social Services and Public Safety (the Department /DHSSPS) and three non-departmental public bodies (the NDPBs). The report also considers the audits of the new health and social care bodies created on 1 April 2009, namely; the Health and Social Care Board (HSC Board), the Public Health Agency (PHA), the Business Services Organisation (BSO) and the Patient and Client Council (PCC). It does not cover the results of the audit of the Department which have already been reported[2]. A full list of the bodies covered and their gross expenditure for 2009-10 and 2010-11 is shown at Figure 1.

Key report observations

1.3.1 Key report observations to note are:

- Two Trusts (Belfast and Northern Trust) required additional funding of £28 million to "break even" in 2009-10. In 2010-11 the Northern Trust required additional funding of £6 million. The HSC sector needs to continue to have a sharp focus on managing available resources more effectively so that it can live within its means. (paragraphs 2.2.2 -2.2.5)

- Management costs in 2010-11 were £125 million. This is £17.9 million (17 per cent) above the costs incurred in 2006-07, the final year before the Review of Public Administration reforms. The Department has advised that if the 2006-07 management costs were rebased to 2010-11 levels factoring in inflation, pay modernisation progression and a change in employer's superannuation rate, there would be real term savings on management costs of £17.3 million reducing these to £107.7 million. This rebased figure for 2010-11 is £0.6 million higher than the actual management costs recorded in 2006-07. We would have expected greater savings to have been achieved in management

1 Five non-regional trusts and the NI Ambulance Service HSC Trust
2 Financial Auditing and Reporting: General Report by the Comptroller and Auditor General for Northern Ireland – 2010, 22 December 2010 and Financial Auditing and Reporting: General Report by the Comptroller and Auditor General for Northern Ireland – 2011, 25 October 2011.

Figure 1 Health and Social Care Bodies covered by this report

	Gross expenditure	
	2009-10 Restated[3] £'m	2010-11[4] £'m
TRUSTS		
Belfast Health & Social Care Trust	**1,290**	**1,179**
Northern Health & Social Care Trust	**607**	**613**
South Eastern Health & Social Care Trust	**530**	**517**
Western Health & Social Care Trust	**531**	**504**
Southern Health & Social Care Trust	**524**	**522**
NI Ambulance Service Health & Social Care Trust	**59**	**55**
BOARD		
Health & Social Care Board	**954**	**961**
SPECIAL AGENCIES		
NI Medical & Dental Training Agency	**53**	**54**
NI Blood Transfusion Service	**26**	**24**
NI Guardian Ad Litem Agency	**4**	**4**
SPECIAL HEALTH BODIES		
Business Services Organisation	**112**	**108**
Public Health Agency	**43**	**46**
Patient & Client Council	**1**	**2**
NDPBS		
Regulation & Quality Improvement Authority	**7**	**7**
NI Social Care Council	**4**	**4**
NI Practice & Education Council	**2**	**1**
Total gross expenditure	**4,747**	**4,601**

3 Figures restated due to a change in accounting policy in line with Department of Finance and Personnel guidance
4 The reduction in expenditure between 2009-10 and 2010-11 is largely due to significant asset impairments arising from an asset revaluation exercise completed in 2009-10 (See para. 2.2.11).

Section 1: Introduction

and administration costs across the HSC sector. The Department does not accept that greater savings could have been achieved in this area and points to the fact that real term savings of £17.3 million have been delivered within the context of the £38.1 million which is the Trust element of the total RPA saving of £49.3 million as illustrated in Figure 10. (paragraphs 2.2.8 and 4.2.2)

- In March 2011 the Department issued guidance to the HSC sector reminding them to ensure that prompt payment calculations also include invoices paid on time under other agreed terms rather than reporting all invoices paid against a 30 day target. When measured against the reissued guidance performance against this target has improved. (paragraphs 2.2.14 and 2.2.15)

- Additional salary payments of £25,946 made to senior executives in the Belfast Trust in 2010-11 were not authorised by the Department. (paragraph 2.4.3)

- While it is acknowledged that the Belfast Trust is now robustly addressing the matter of the Belvoir Park hospital site security breach it is disappointing that the Information Commissioner's Office was not informed as soon as the Trust became aware of this issue. (paragraph 2.4.15)

- Operational performance against most measures such as waiting times has declined considerably since March 2009. Waiting time targets have not been achieved for inpatient treatment, outpatient appointments, diagnostic tests or emergency care during 2010-11. At the end of March 2011:

  - 31,909 patients (30 per cent) had waited longer than the target nine weeks for a first outpatient appointment;

  - 17,630 patients had waited more than 13 weeks for inpatient treatment and 1,261 of them had waited more than 36 weeks;

  - 12,043 patients were waiting longer than nine weeks for a diagnostic service or more than 13 weeks for a day case endoscopy; and

  - although the number of patients waiting more than 12 hours in an emergency care department showed an improvement with 850 waiting compared to 1,239 twelve months earlier, the target is that no patient should wait for this period of time. (paragraphs 3.3.1 – 3.3.5 and 3.3.8 – 3.3.10)

- Following the backlogs of unread x-rays within the Western Trust the Department commissioned the Regulation and Quality Improvement Authority (RQIA) to undertake an

independent review of the handling and reporting arrangements for plain x-ray radiological investigations across Northern Ireland. (paragraph 3.3.7)

- Delays in review appointments, for which no specific targets have been set, have been reported. The Department has indicated that by March 2012 all such patients should be seen within the timescale prescribed by their clinicians. (paragraph 3.3.11)

- The primary objective of all HSC initiatives should be the delivery of better quality care to patients. It is important that lessons learnt from organisational changes are applied in both the health sector and the wider public sector. (paragraph 4.1.1)

- Under the Review of Public Administration reforms, HSC organisations were set the target of achieving £53 million in efficiency savings by 2010-11. The Department has calculated that £49 million has been delivered with the remaining £4 million to be achieved by 2012-13 through shared services. (paragraph 4.2.2)

- The recent Public Inquiry into the Clostridium Difficile (C Difficile) infection in Northern Trust Hospitals recognised the additional risk to patient safety and quality of care arising at times of organisation change. Measures to improve efficiency must be considered in the context of their impact on the control environment. (paragraphs 4.2.5-4.2.7)

- Many of the business systems used in the HSC sector are more than 20 years old. The cost of maintaining the existing financial systems continues to rise alongside the increasing risk of systems failures. Efficiencies can be realised across the HSC sector through the Business Services Transformation Programme and will require considerable long-term investment. (paragraphs 4.3.1-4.3.4)

- The Department and HSC bodies procured expenditure of £673 million in 2009-10 and £750 million in 2010-11. (paragraph 5.1.1)

- Weaknesses in contract expenditure controls arising across the five non-regional trusts were reported in 2010-11 and trusts are addressing these weaknesses. With the potential regularity and litigation risks associated with poor contract management, added to the potential value for money rewards arising from improvement, these weaknesses must be addressed as a priority. (paragraphs 5.2.1 – 5.2.4)

- The use of Single Tender Actions across the HSC sector has reduced from £9.8 million in 2006-07 to £5.4 million in 2010-11 and this is a welcome development. (paragraph 5.3.2)

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Financial Performance and Governance

2.1.1 The Department requires that HSC bodies meet a number of financial targets each year and that they disclose their financial performance in their annual reports. Some of these targets are statutory, while others represent best practice. This section of the report provides an overview of HSC bodies' financial performance in 2009-10 and 2010-11, and also discusses governance issues arising in the 2010-11 audits.

"Break even"

2.2.1 HSC bodies are required to conform to the general requirement of good financial management. Additionally, trusts are required by statute[5] to ensure that their income is sufficient to meet their expenditure taking one year with another to achieve "break even".

2.2.2 Overall funding for the six trusts increased by 10 per cent to £3.3 billion in 2009-10 when compared to 2008-09 figures of £3 billion. Funding for 2010-11 reduced to £3.2 billion. In 2009-10 all HSC bodies achieved their financial targets to "break even" with the Northern and Belfast Trusts requiring additional funding of £17.6 million and £10.6 million respectively to do so. All HSC bodies met "break even" in 2010-11 with the Northern Trust again requiring additional funding of £6 million. When asked why this funding was required the Department commented that it is a normal part of proactive financial management to reprioritise resources and to redistribute them to maximise effective deployment whilst avoiding overspends.

2.2.3 Figure 2 sets out trust performance against "break even" over the last 3 years. Performance over the last two years appears to have stabilised.

2.2.4 The Capital Resource Limit (CRL) is a fixed annual capital spending limit established for all HSC bodies with capital expenditure and is set by the Department. The limits are based on the Department's own capital budget allocation which was £187.3 million and £209 million for 2009-10 and 2010-11 respectively. In both years all HSC bodies met their CRLs.

2.2.5 The HSC sector needs to continue to have a sharp focus on managing available resources more effectively so that it can live within its means.

Best practice targets

2.2.6 The financial regime also measures management costs as a best practice measure of trusts' efficiency and HSC sector performance in paying invoices promptly.

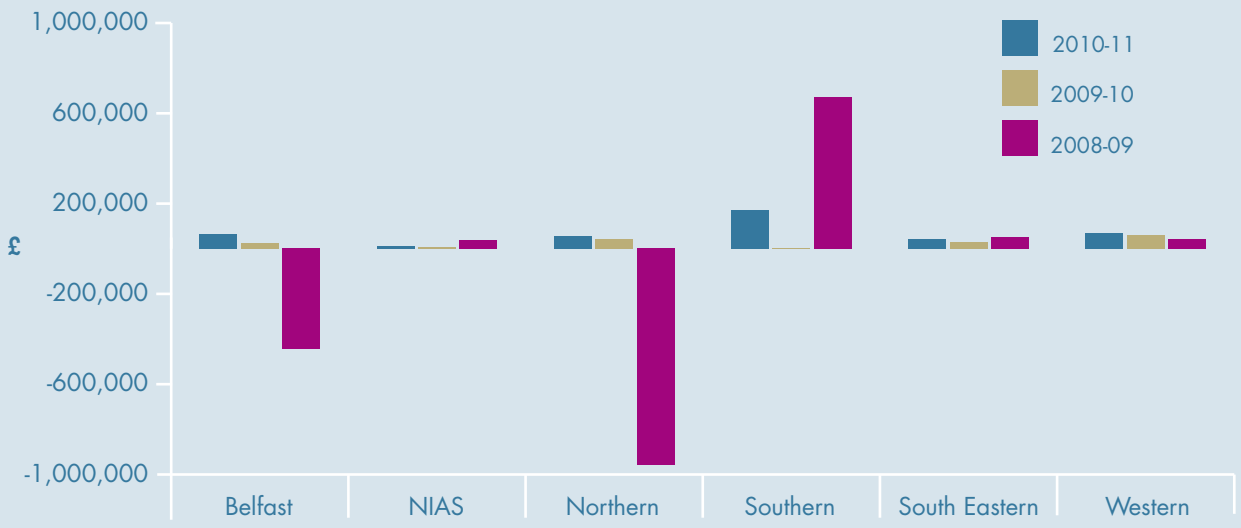
Management costs

2.2.7 All trusts are expected to maintain their management costs[6] within a ceiling of five per cent of overall income. For 2009-10 and 2010-11 management costs for the five non-regional trusts remained within this ceiling. Following the Review of Public Administration (RPA) reforms, which started on 1 April 2007, it was anticipated that management and administration costs across the HSC sector would reduce significantly.

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

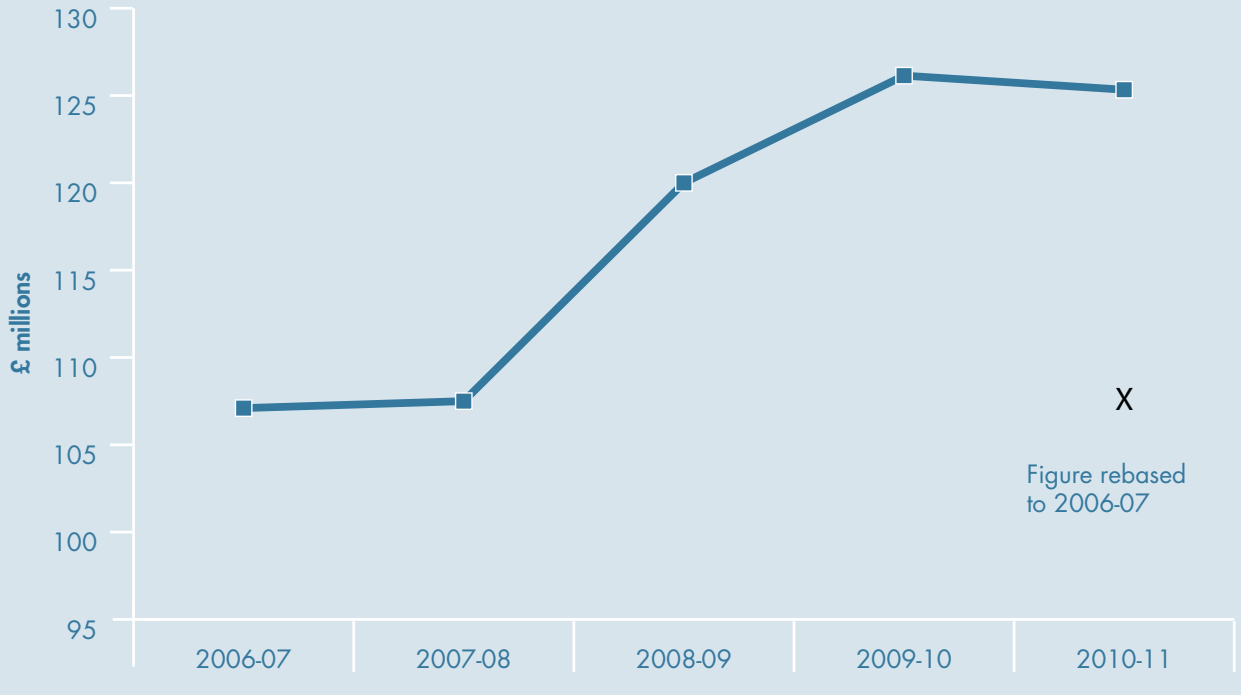
6 The calculation of management costs is based on the Audit Commission definition and reflected in Departmental guidance to trusts. In a normal break even scenario, expenditure should be equivalent to income.

Figure 2: Trusts' performance against "break even" from 2008-11



Source: HSC Trust 2009-10 and 2010-11 accounts

Figure 3: Trust management costs from 2006-07 to 2010-11



Source: HSC trust accounts

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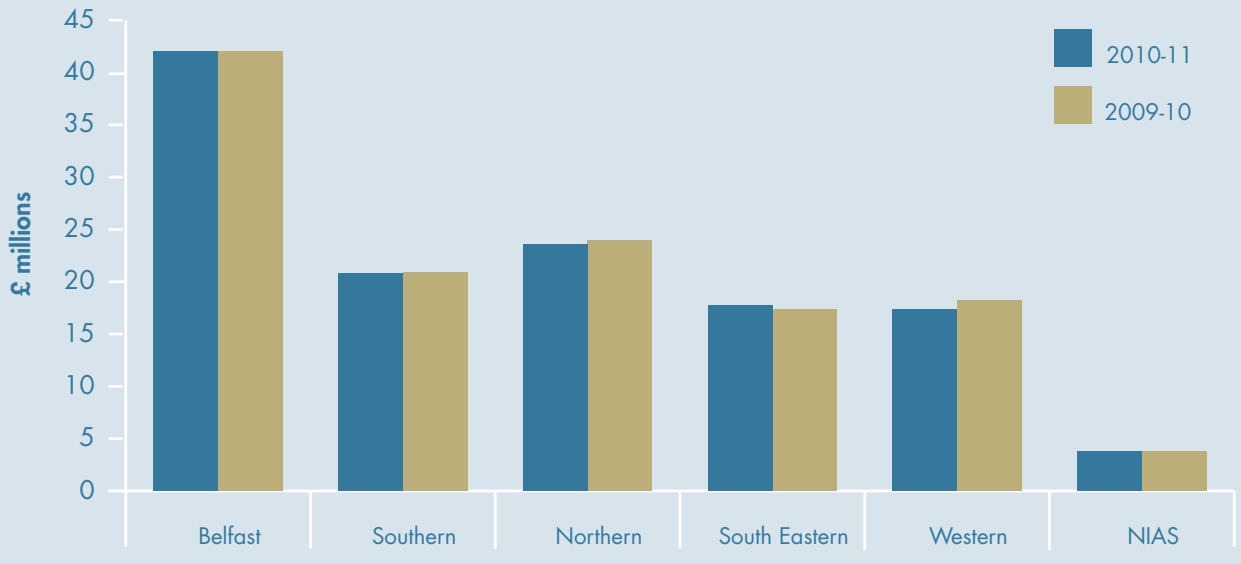
2.2.8 In 2007-08 management costs for the six trusts were recorded as increasing to £107.5 million from the restated figure of £107.1 million reported in the previous year. These costs increased further to £121 million in 2008-09 and £126 million in 2009-10. While costs have fallen slightly to £125 million in 2010-11 this is still £17.9 million (17 per cent) higher than the management costs incurred by the 18 legacy trusts and NIAS in 2006-07, the final year before the RPA reforms. See Figure 3. The Department has advised, that if the 2006-07 management costs were rebased to 2010-11 levels factoring in inflation, pay modernisation progression and a change in employer's superannuation rate, there would be real terms savings on management costs of £17.3 million reducing these to £107.7 million. This rebased figure for 2010-11 is £0.6 million higher than the actual management costs recorded in 2006-07. We would have expected greater savings to have been achieved in management and administration costs across the HSC sector, particularly given the Department's calculation in paragraph 4.2.2 and Figure 10 that RPA savings to date total £49.3 million. The Department does not accept that greater savings could have been achieved in this area and points to the fact that real terms savings of £17.3 million have been delivered within the context of the £38.1 million which is the Trust element of the total RPA savings of £49.3 million as illustrated in Figure 10.

Figure 4: Management costs broken down by trust



Source: HSC trust 2009-10 and 2010-11 accounts

2.2.9 Management costs are broken down by trust in Figure 4. As expected these costs are significantly higher in the larger trusts.

2.2.10 When considered as a percentage of total income, management costs reduced for all of the trusts in 2009-10 and increased marginally for all but one trust in 2010-11. However due to the fact that prior year figures in trust accounts have had to be restated every year since 2008-09[7], comparison of such costs between years is difficult.

2.2.11 On the face of it, the 2009-10 reduction appeared to be down to better management of administration costs. However, the calculation method changed in 2009-10 and the trusts were funded for the loss in value of their land and buildings identified through the revaluation exercise carried out that year[8]. The level of this loss in value which is known as impairments, varied across the trusts - ranging from £1 million in the Northern Ireland Ambulance Service Trust (NIAS) to over £115 million in the Belfast Trust in 2009-10. For 2010-11 the five non-regional trusts management costs continued to remain well within the five per cent of income ceiling set by the Department.

Prompt payment

2.2.12 All HSC bodies are required to pay their invoices promptly[9]. Best practice suggests that 95 per cent of payments to creditors should be made within the agreed terms, or 30 days after receipt of a valid invoice where no terms have been agreed.

2.2.13 In 2008[10] DFP drew Accounting Officers' attention to the need to ensure that all possible steps were taken by Northern Ireland Civil Service departments and their public bodies to pay suppliers as promptly as possible and to seek to meet the ten day prompt payment commitment made in response to the current economic position. This guidance was reissued in February 2010 and the Department asked all HSC bodies to review their own processes and systems for paying suppliers. In both 2009-10 and 2010-11 the Department monitored compliance against the 30 day best practice target on a monthly basis. The Department told us that all organisations are continually reminded of the need to pay valid invoices promptly but an impediment highlighted by HSC bodies is the age and limited functionality of payment systems. It anticipates that the procurement of new shared services systems will enable the HSC sector to reduce the standard time taken to pay suppliers. The Department expects these systems to be in place no later than 2013.

2.2.14 In March 2011 the Department issued guidance[11] to the HSC sector reminding them to ensure that prompt payment calculations also include invoices paid on time under other agreed terms[12]

7 This is in line with changes to the format of the accounts, the move to International Financial Reporting Standards and changes in accounting policy.
8 International financial reporting standards require that every five years, land and buildings in the public sector must be professionally valued
9 The Department requires that all HSC bodies pay their non-HSC trade creditors in accordance with the Confederation of British Industry's Better Payments Practice Code and associated Government Accounting rules, and that they disclose annually the extent to which they comply with these requirements.
10 Circular DAO(DFP) 12/08, Department of Finance & Personnel, 27 November 2008
11 HSC (F) 04/2011 circular on Prompt Payment Compliance
12 Agreed terms can extend up to 60 days

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rather than reporting all invoices paid against a 30 day target. This is permitted by Managing Public Money Northern Ireland, but such reporting appears in our view to be at odds with the spirit of paying suppliers more promptly. The Department has informed us that it remains committed to the prompt payment of suppliers and that the guidance was issued to ensure consistency in reporting prompt payment performance across the health sector.

2.2.15 We note the anticipated impact the new shared services systems are expected to have on the HSC sector's prompt payment performance after 2013. In the interim we would urge the Department and the HSC bodies to explore other ways to pay their suppliers more promptly and move towards the ten day prompt payment commitment set by DFP. Many small businesses in Northern Ireland rely heavily on the HSC sector for their cash flow and delays in payment may have a significant detrimental impact on their ability to manage their business.

2.2.16 As has been the case in previous years, compliance with the prompt payment target continues to present a considerable challenge to HSC bodies. When calculated against the original guidance, neither the Board nor any of the trusts were able to comply with the 95 per cent best practice target in 2009-10.

2.2.17 After restating the 2009-10 figures in 2010-11, in line with the reissued guidance, the Western Trust and NIAS met the best practice compliance target for both years. See Figure 5. The rest of the larger HSC bodies achieved at least 90 per cent compliance in 2010-11. When measured against the reissued guidance performance seems to have improved.

Financial Summary

Revenue

2.3.1 Financial pressures on HSC bodies continued to build in 2010-11. In England, the National Health Service (NHS) has been guaranteed that health spending will increase in real terms in each year of the Parliament and efficiency savings that are realised will be re-invested in front-line services. Under Comprehensive Spending Review 2007 (CSR07) plans, the HSC sector in Northern Ireland was required to deliver cumulative savings of £249 million by the end of 2010-11 which was then increased by a further £105 million. For 2010-11 HSC Board was allocated approximately £3.6 billion for Hospital, Community Health and Personal Social Services' expenditure, equivalent to ten million pounds a day.

2.3.2 In early 2010 trusts were forecasting significant deficits for 2010-11. The HSC Board, working with the trusts, examined the deficits forecast in individual trust delivery plans. These reviews led to a more accurate financial forecast consistently applied across the trusts. Financial stability assessments were also completed in parallel to obtain assurance

Figure 5: Compliance against prompt payment best practice target

Source: HSC trust 2009-10 and 2010-11 accounts

over deliverability of savings plans. Action plans were agreed with the trusts and PHA and progress against these plans is regularly reported to the HSC Board.

2.3.3 Throughout 2010-11 the five non-regional trusts were projecting major but steadily declining deficits. The Northern Trust was again provided with additional funding of £6 million (known as a control total) to ensure that services continued to be deliverable within its area.

2.3.4 The fact that two trusts have had to be given additional funding of approximately £35 million over the past two years is unusual for Northern Ireland. The Department has advised that this is due to exceptional circumstances where the combined effects of unceasing demand growth coupled with static or reducing resources available to the HSC sector required short-term subventions. This was in order to preserve financial balance within and across organisations, whilst ensuring that the full range of services to these particular resident populations could be sustained. There is a risk that uncertainty over funding may lead to a short-term approach to planning to achieve "break even" with underspends arising through the adoption of a risk averse approach. Alternatively there may be a risk that HSC bodies assume the availability of additional year-end funding prompting spending commitments which eventually prove to be undeliverable in a year where additional allocations do

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not become available. However, it is important to note that the outturn in 2009-10 showed an underspend of £5.4 million and in 2010-11 an underspend of £4.5 million. These represent 0.1 per cent of the Department's total budget. This performance clearly demonstrates the high level of financial management and control exercised by the Department.

Capital

2.3.5 CSR07 covered the period 2008-09 to 2010-11 and budgeted £728 million for capital investment within the Department. This was, however, reduced by £104 million to £624 million to reflect:

- a significant decline in income from surplus asset sales;
- the impact of swine flu; and
- the need to meet £21.5 million of savings (the Department's share of reduced capital expenditure across the Northern Ireland block).

2.3.6 The Northern Ireland Executive's Investment Strategy for Northern Ireland 2008-18 detailed how this provision would be split across the three main areas of: primary care, public safety and technology and hospitals' modernisation. The key driver of the investment programme continues to be the need to transform healthcare delivery by providing more treatment and care closer to where people live and work. DFP and the Strategic Investment Board are currently conducting a capital review across the Northern Ireland block and will publish an updated Investment Strategy for Northern Ireland shortly for public consultation in parallel with the Programme for Government.

2.3.7 The Department told us it is difficult to plan the delivery of its priorities until medium-term capital allocations are known. Moreover it previously advised the Health Committee that £100 million of annual allocations are required for fixed costs. This includes for example, minor capital works such as repairs, purchase of medical and screening equipment and design, procurement and installation of Information & Communication Technology (ICT) systems, before money is spent on buildings.

2.3.8 The opening capital budget for 2009-10 was £209.2 million. However, the outbreak of swine flu led to further pressures on the capital budget and resulted in the final approved capital budget being £187.3 million, with a further £22 million ring-fenced for swine flu. The approved capital budget for 2010-11 was £209 million. Projects completed during 2009-10 and 2010-11 include the new Downe Hospital, Royal Group of Hospitals' Medicine Management Technology (Victoria Pharmaceuticals), Daisy Hill Renal Unit, the Trauma and Orthopaedic Centre at Craigavon Hospital, Portadown Health and Care Centre, Ulster Hospital Phase A, Altnagelvin Phase 3.2A and Phase 3.2B, Child and Family Unit at Forster Green and the Mobile CT Scanner in Antrim.

Figure 6: Progress of capital projects against milestones

Milestone	Current position
Completion of a new mental health facility at Gransha Park by 2010	This project was postponed due to capital funding constraints. Design is now complete and construction of the new £10.7 million facility is underway. The revised target date for completion is 2012.
Completion of £100 million Phase A of the Ulster Hospital redevelopment by 2010	The final element of this project, the £47 million Critical Care Block, was completed on target and has been fully operational since November 2010.
Opening of the new £267 million South West acute hospital by 2012 (Private Finance Initiative)	Construction of this new major facility is well underway and expected to be completed on target in 2012.
A new local enhanced hospital in Omagh by 2013	The business case for the first phase of this project, £80 million, was approved in August 2011. It is planned that, following design and procurement, construction of the facility will be completed by 2016.

2.3.9 In working towards these goals the Investment Strategy established a number of key milestones. Progress against a number of significant projects is reported in Figure 6.

2.3.10 The Department has provided the following additional comments on the capital programme:

- over a third of the health estate is more than 50 years old;
- up to two-thirds of the buildings require significant investment to bring them up to current standards;
- for the four-year Budget 2010 period, a total capital allocation of £856 million has been made;
- £310 million of the available capital spend will be spent on fixed costs such as ICT, essential maintenance of the estate and replacement of critical clinical equipment and emergency vehicles;
- £308 million is already committed to construction projects underway; and
- approximately £238 million is available for the next four years to address all new investments.

Position on the accounts for 2009-10 and 2010-11

2.4.1 The Department sets the timetable for the laying of HSC bodies' accounts. In 2009-10 and 2010-11 the larger HSC bodies, (i.e. the trusts, HSC Board and the PHA) laid their accounts before the Assembly rose for summer recess in line with Departmental timescales. This was a considerable achievement given the limitations of the systems supporting the

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finance function (referred to in Section 4) and the fact that three[13] of the newly created bodies were required to meet the deadline.

2.4.2 For 2009-10 the financial and regularity audit opinions on all of the arm's length bodies across the HSC sector were clear. That is, there were no issues arising from the audits that were considered to have a material impact on the opinions given on these accounts. This year again, the audit of the accounts did not identify any issues impacting on the financial audit opinion. However, an issue arose in the Belfast Trust which led to a limitation in the scope of the regularity opinion. Details of the qualification are set out below along with a number of governance issues that were identified in the Trust this year. In 2010-11, we also reported on weaknesses in contract expenditure controls identified across the five largest trusts. These are discussed in more detail in Section 5.

Belfast Trust - Regularity issue arising from unauthorised senior executive salary payments in 2010-11

2.4.3 Our report on the 2010-11 financial statements for the Belfast Trust noted the circumstances surrounding additional salary payments of £25,946,[14] made to senior executives in the Belfast Trust that had not been authorised by the Department.

2.4.4 In early 2009 the Trust introduced an additional responsibilities' allowance as a means of remunerating those senior executives who had assumed additional duties, following an internal restructuring. The Trust notified the Department in July 2009 of its intention to award these salary allowances and in August 2009 the Trust's Remuneration Committee approved the payments which commenced from September 2009, effective from 1 June 2009.

2.4.5 Although the Department notified the Trust in September 2009 that the additional responsibility allowances were not approved, the Trust continued to pay them. The Department became aware of the payments in August 2010 and commissioned an Internal Audit review into the matter. The review concluded that the Trust had acted outside its authority and its Remuneration Committee had not sought Trust Board approval for this increase in salary nor had it queried the absence of Departmental approval. In line with DFP's pay remit guidance,[15] once a Department is satisfied that a pay award is justified, the award must be submitted to DFP for approval. In March 2011, DFP approved additional responsibility allowances paid by the Trust from 1 March 2011, until the posts involved undergo re-evaluation, but refused retrospective approval or authorisation to write off the irregular expenditure incurred from June 2009 to February 2011.

2.4.6 The Trust can point to a net reduction in total senior executive salaries following the restructuring and payment of the additional responsibility allowances. However, as these allowances were not authorised by the Department and DFP,

13 The HSC Board and PHA were required to meet pre summer recess deadlines from 2009-10. Since 2010-11 the Business Services Organisation has also been required to meet this deadline.
14 These payments relate to the period 1 April 2010 to 28 February 2011 and are included in the 2010-11 financial statements.
15 Pay Remit Approval Process and Guidance (2009-10)

they were irregular and the regularity opinion on the Trust's 2010-11 financial statements was limited to exclude the total sum involved.

2.4.7 In 2008-09 the regularity opinion was limited on a similar issue in the Northern Ireland Fire and Rescue Service financial statements following re-evaluation of posts and an irregular salary award to non-uniformed directors. It is disappointing that a further case has arisen of unapproved senior staff remuneration in another of the Department's arm's length bodies. The Department has asked us to highlight that NIFRS and HSC trust senior executives do not share the same job evaluation scheme or pay scales.

Belfast Trust - Governance issues arising in 2010-11

Information governance

2.4.8 During 2010-11 a serious data breach was reported in respect of old medical and other records held in storage at the former Belvoir Park hospital site which has been vacant since 2006. The Belfast Trust found that a number of buildings on the site had been unlawfully entered. Investigations into the incident revealed that information stored at the site, including former patient records and x-rays, had been accessed. Photographs were taken by the perpetrators and published on the internet showing clinical equipment, minutes of meetings, x-ray folders and ward diaries. The Trust immediately declared this as a Serious Adverse Incident[16] and this was reported to the HSC Board. The Trust advises that there is no evidence to suggest that information or sensitive patient data was stolen from the Belvoir Park hospital site although this cannot be confirmed.

2.4.9 The Trust inherited the former hospital site in 2007 from a previous legacy Trust and was not made aware that records were being held there. Any records held at the Belvoir Park hospital site relating to the 1950s, 1970s and 1990s are outside any required retention period and can be disposed of once the site is deemed safe. The removal of information has been hampered by severe asbestos contamination which has led to large quantities of the records having to be destroyed. In addition, the Trust notes that any records relating to current patients were transferred to the replacement cancer unit within the Belfast City Hospital.

2.4.10 An action plan has been developed to clear all information assets from the site. The incident has been referred to the Information Commissioner's Office (ICO) for investigation. The ICO will determine whether the Trust took appropriate action to secure the information held and to ensure the protection of personal sensitive data.

2.4.11 The Trust has commenced its own review to identify whether sensitive data and information is being held in other decommissioned hospital buildings. Management has recently completed an inventory of all non-operational buildings

16 Departmental guidance describes these incidents as serious enough to warrant regional action to improve safety or care within the broader HSC; incidents which are likely to be of public concern; and incidents which are likely to require an independent review.

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within the Trust. The next step of the review is to determine whether any of these buildings contain any sensitive data left behind when the buildings were decommissioned. In addition, the Trust has revised its decommissioning policy to ensure that such incidences do not occur in the future.

Clinical governance

2.4.12 In November 2009 concerns were raised with the Medical Director of the Belfast Trust regarding the care and treatment provided to five patients by the School of Dentistry. These patients had been referred for surgery following a diagnosis of oral cancer and could potentially have been referred at an earlier stage of their illness. In June 2011 an Independent Inquiry commissioned by the Minister concluded that there were serious deficiencies in the quality of care provided by the School of Dentistry and the Trust to the patients recalled for review appointments, which may have impacted adversely on the health of some of them to a significant degree and certainly had the potential to do so. The Inquiry also found that there was a failure by the Trust to communicate fully, effectively and promptly with the other HSC bodies in the appropriate manner and a failure by the Department to be proactive in seeking further communication from the Trust.

2.4.13 The Department has advised that:

- a short-life Working Group has been convened to draft an action plan to address the 45 recommendations made by the Inquiry. This Group comprises stakeholders from the PHA, HSC Board, the Belfast Trust, the Queen's University of Belfast, the PCC and the Department itself;

- this action plan was to be submitted to the Minister in October 2011, with quarterly reports on implementation thereafter;

- the action plan will also be shared with the Health Committee, prior to its full publication in order to promote public confidence; and

- each action point contained within the plan will clearly set who is responsible for its implementation. This will facilitate follow-up monitoring by the Department.

Transparent handling of control weaknesses

2.4.14 After the financial statements of the Belfast Trust were certified by the C&AG on the 23 June 2011, the Department disclosed concerns over potential shortcomings in the procurement of the security contract at Belvoir Park hospital site in its Departmental Statement on Internal Control. It is very disappointing that the Trust, which has direct responsibility for the management of the contract, did not advise us of this issue before its accounts were certified. Where weaknesses in controls are known to the Trust these should be dealt with openly and transparently. We wrote to the Chief Executive of the Trust expressing our

concern over this lack of transparency and openness and seeking a full explanation of the circumstances surrounding this issue and have subsequently received a response. Our report on weaknesses in contract expenditure controls in all five non-regional trusts is at Section 5. The Department has told us that the issues covered in the report will be addressed in its review of procurement practice, announced by the Minister in his Assembly statement of 28 June 2011.

2.4.15 While it is acknowledged that the Trust is now robustly addressing the matter of the Belvoir Park hospital site security breach, it is regrettable that the ICO was not informed as soon as the Trust became aware of this issue.

Key points

2.5.1 Key points to note are:

- Overall funding for the trusts has increased by 10 per cent in 2009-10 to £3.3 billion when compared to 2008-09 figures of £3 billion. Funding has reduced to £3.2 billion for 2010-11. Two Trusts (Belfast and Northern Trust) required additional funding of £28 million to "break even" in 2009-10. In 2010-11 the Northern Trust required additional funding of £6 million. The HSC sector needs to continue to have a sharp focus on managing available resources more effectively so that it can live within its means. (paragraphs 2.2.2 -2.2.5)

- Management costs in 2010-11 were £125 million. This is £17.9 million (17 per cent) above the management costs incurred in 2006-07, the final year before the RPA reforms. The Department has advised, that if the 2006-07 management costs were rebased to 2010-11 levels factoring in inflation, pay modernisation progression and a change in employer's superannuation rate, there would be real terms savings on management costs of £17.3 million reducing these to £107.7 million. This rebased figure for 2010-11 is £0.6 million higher than the actual management costs recorded in 2006-07. We would have expected greater savings to have been achieved in management and administration costs across the HSC sector. The Department does not accept that greater savings could have been achieved in this area and points to the fact that real term savings of £17.3 million have been delivered within the context of the £38.1 million which is the Trust element of the total RPA saving of £49.3 million as illustrated in Figure 10. (paragraphs 2.2.8 and 4.2.2)

- In March 2011 the Department issued guidance to the HSC sector reminding them to ensure that prompt payment calculations also include invoices paid on time under other agreed terms rather than reporting all invoices paid against a 30 day target. When measured against the reissued guidance performance

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against this target has improved. (paragraphs 2.2.14 and 2.2.15)

- We note the anticipated impact the new shared service systems are expected to have on the HSC sector's prompt payment performance. In the interim we would urge the Department and the HSC bodies to explore other ways in which they can pay their suppliers more promptly and move towards the ten day prompt payment commitment set out by DFP. (paragraph 2.2.15)

- Over a third of the health estate is more than 50 years old. The capital budget for 2010-11 was £209 million. The Department advised that approximately £100 million is required recurrently to meet fixed costs for example, minor capital works such as repairs, purchase of medical and screening equipment and design, procurement and installation of ICT systems, before money is spent on buildings. (paragraphs 2.3.7 – 2.3.10)

- The Department sets the timetable for the laying of HSC bodies' accounts. In 2009-10 and 2010-11 the larger HSC bodies, (i.e. the trusts, the PHA and the HSC Board) laid their accounts before the Assembly rose for summer recess. This was a considerable achievement given the limitations of the systems supporting the finance function referred to in Section 4 and the fact that three of the newly created bodies were required to meet the deadline. (paragraph 2.4.1)

- Additional salary payments of £25,946 made to senior executives in the Belfast Trust in 2010-11 were not authorised by the Department. (paragraph 2.4.3)

- After the financial statements of the Belfast Trust were certified by the C&AG on the 23 June 2011 the Department disclosed concerns over potential shortcomings in the procurement of the security contract at Belvoir Park hospital site in its Departmental Statement on Internal Control. It is very disappointing that the Trust, which has direct responsibility for the management of the contract, did not advise us of this issue before its accounts were certified. (paragraph 2.4.14)

- While it is acknowledged that the Belfast Trust is now robustly addressing the matter of the Belvoir Park hospital site security breach it is regrettable that the ICO was not informed as soon as the Trust became aware of this issue. (paragraph 2.4.15)

Section 3:
Operational Performance – Access to Health

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Operational Performance – Access to Health

3.1.1 Key performance measures covered in this section are waiting times for outpatient appointments, inpatient treatment, diagnostic tests and emergency care targets.

PAC Report on the Performance of the Health Service

3.2.1 The following sections of the report look at performance against waiting list targets since the Public Accounts Committee (PAC) reported in 2010[17] following our 2008 report on the performance of health services in Northern Ireland.[18] The PAC report identified that the success in tackling waiting times was, at least in part, as a result of funding additional treatments by the independent sector. The Committee warned of, and the Department acknowledged, the dangers of "a quick fix approach" since it "fails to deliver sustainable solutions to the waiting time problem, largely because it does not address the underlying causes of long waiting times". The recent Appleby review[19] notes that patients waiting excessively long times to receive treatment in hospital, is a very visible indicator of a health system not working efficiently.

Performance against waiting list targets over certain specialties

3.3.1 Priorities for Action 2011 sets out specific targets and actions to be achieved by the 31 March 2011 over seven priority areas. The next paragraphs consider performance since March 2009 against the following waiting list targets:

- Elective care (consultant-led): by March 2011 the HSC Board and trusts should ensure no patient waits longer than 9 weeks for a first outpatient appointment and 9 weeks for a diagnostic test, the majority of inpatients and daycases should be treated within 13 weeks and no patient should wait longer than 36 weeks for treatment; and

- Emergency care: from April 2010 HSC Board and trusts should ensure 95 per cent of patients attending any Accident & Emergency department are either treated and discharged home, or admitted, within four hours of their arrival in the department. No patient should wait longer than 12 hours.

3.3.2 Figures reported are averages across specialties and geographical areas. The HSC sector has not been able to achieve any of these targets consistently and operational performance against measures such as waiting times has declined considerably since March 2009.

Outpatients

3.3.3 In recent years, the annual number of outpatient attendances has remained fairly static. The number of people waiting at the end of March 2010 for an appointment was 86,501, nearly 26 per cent higher than a year earlier. By the end

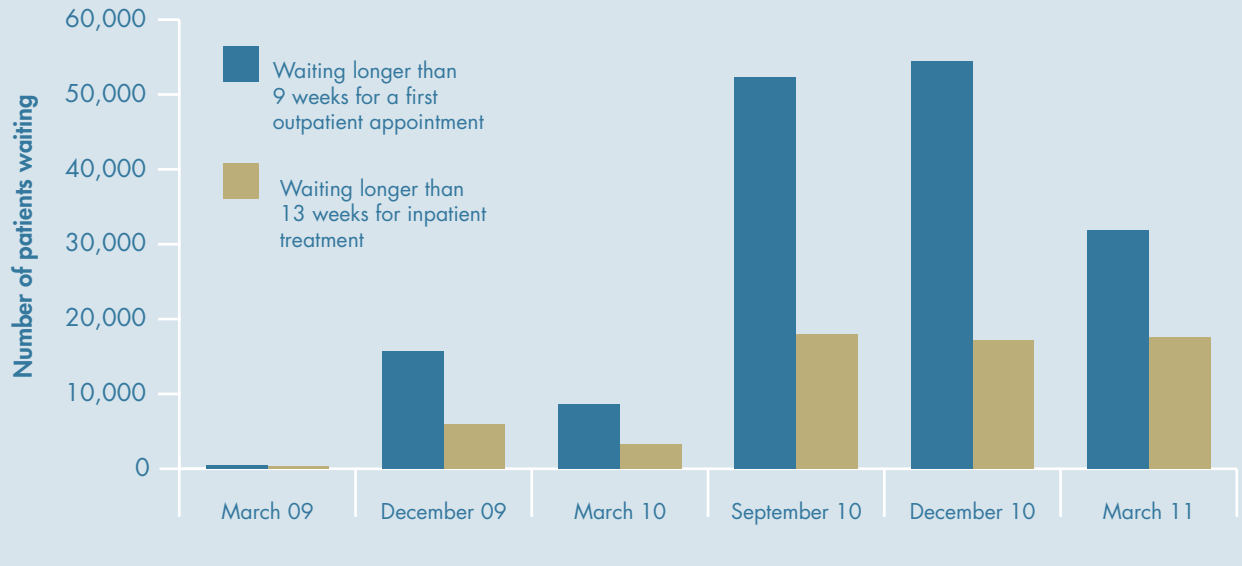
17 On 12 November 2009 the Public Accounts Committee held an evidence session to discuss the 2008 report. Subsequently the PAC issued a Report on the Performance of the Health Service in Northern Ireland, 35/09/10R, 21 January 2010.
18 The Performance of the Health Service in Northern Ireland, NIA 18/08-09, 1 October 2008.
19 Rapid Review of Northern Ireland Health and Social Care funding needs and the productivity challenge 2011-12 –2014-15, Professor John Appleby, March 2011.

of March 2011, the figure had further increased to 106,227. During 2009 and 2010 as the number of people waiting for an outpatient appointment increased, the length of waiting time also increased. Of those people waiting at the end of March 2011, 31,909 (30 per cent) had waited longer than the target nine weeks for a first outpatient appointment. See Figure 7. Performance varied across the trusts ranging from 10,525 patients waiting longer than nine weeks in Belfast Trust hospitals to 2,830 patients waiting longer than nine weeks in Southern Trust hospitals.

Inpatients

3.3.4 During the quarter ending March 2011, a total of 47,380 patients received inpatient treatment. 95 per cent of these patients received treatment within HSC trusts, the remaining patients were treated in the independent sector. At the end of March 2011, there were 17,630 patients waiting more than 13 weeks for inpatient treatment compared to 3,252 patients in March 2010 and 387 patients in March 2009. See Figure 7. Again performance varied across the trusts ranging from 8,589 patients waiting longer than 13 weeks for treatment in the Belfast Trust area to 1,618 waiting in the South Eastern Trust area. Of the patients waiting for inpatient treatment in Northern Ireland at the end of March 2011, 1,261 patients were waiting more than 36 weeks.

Figure 7: Performance against Outpatient and Inpatient Waiting Times Targets



Source: DHSSPS

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Diagnostic tests[20]

3.3.5 The total number of patients waiting for diagnostic services at the end of March 2011 was 62,127, marginally higher than the previous quarter. Of those, 12,043 patients were waiting longer than nine weeks for a diagnostic service or more than 13 weeks for a day case endoscopy. This represents a significant increase on the March 2010 level of 1,687. Performance varied across the trusts with 4,431 patients waiting longer than nine weeks for a diagnostic service and 2,446 patients waiting more than 13 weeks for a day case endoscopy in the Belfast Trust area. Corresponding figures in the South Eastern Trust area were eight and 278 respectively. Statistics relating to the period after March 2010 include all patients waiting for diagnostic services, whereas data reported for previous quarters related only to one of 16 selected diagnostic services. Therefore, current performance is not directly comparable to that in March 2009.

3.3.6 X-rays[21] have a vital role in diagnosing diseases or conditions. Timely completion and ready availability of final x-ray reports[22] is crucial to good clinical decision-making and provision of appropriate clinical care. In view of this, the reporting in July 2010 of a backlog of 18,500 x-rays awaiting analysis in the Western Trust is a major cause for concern. The Trust cleared the backlog by October 2010 but has confirmed that in four of the cases involved, a diagnosis of cancer was subsequently made.

3.3.7 The Department commissioned the RQIA to undertake an independent review of the handling and reporting arrangements for plain x-ray radiological investigations across Northern Ireland. This will be in two phases:

- the initial phase of the review involved a rapid assessment of the current arrangements in place for the handling and reporting of plain x-rays in all HSC trusts across Northern Ireland; and

- the second phase of the review, currently underway, is looking in detail at the circumstances which gave rise to the delays in the reporting of x-rays over the past two years and will identify any action required to avoid such delays recurring.

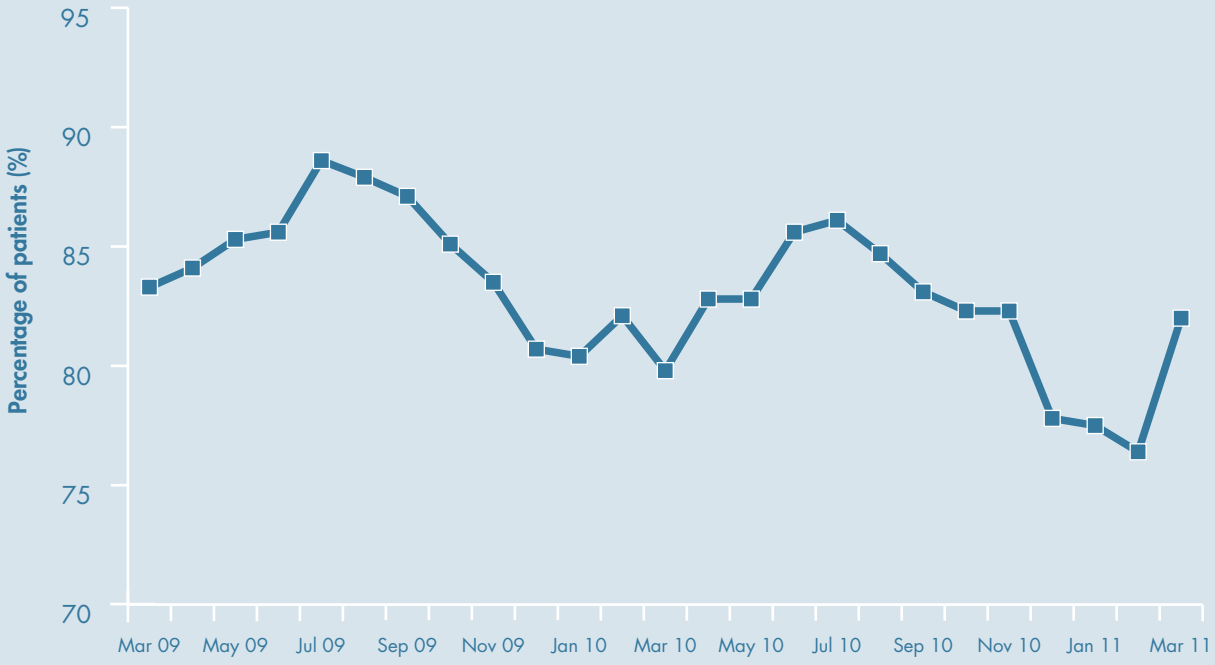
Emergency care targets

3.3.8 Since the introduction of the emergency care waiting time targets in April 2007, the total number of new and unplanned review attendances at emergency care departments has increased by nine per cent from 642,636 in 2007-08 to 699,881 in 2010-11. Since 2007-08, the emergency care waiting time targets have not been consistently achieved across the HSC trusts.

3.3.9 During the last few years, performance in achieving the 4-hour emergency care target has peaked in the month of July but dipped in the period from November to February. See Figure 8. It is likely that winter pressures have contributed to

20 This refers to the provision of an examination, test or procedure to identify a person's disease or condition or to allow a medical diagnosis to be made. The diagnostic waiting time target relates to all tests with a diagnostic element.
21 Plain x-ray imaging is not included within the list of diagnostic tests to which the Priorities for Action target applies
22 Reports on routine x-rays should be completed within 28 days with a deadline of 14 days for reports on non-urgent chest x-rays.

Figure 8: Percentage of patients treated and discharged or admitted within 4 hours



Source: DHSSPS Emergency Care Waiting Times Statistics (January – March 2011)

this deterioration. Performance towards the end of 2010 dipped further when compared to the same period in 2009; although the latest figures for March 2011 show a significant monthly improvement in performance with 82 per cent of patients attending emergency care departments across Northern Ireland, being either treated and discharged or admitted within four hours of their arrival. This compares to 80 per cent in March 2010. Performance varied across trusts in March 2011, ranging from 90 per cent in Southern Trust to 74 per cent in Belfast Trust.

3.3.10 Performance against the 12-hour component of the emergency care waiting time target in 2010-11 may also have been affected by seasonal variations, but it should be noted that, with the exception of March 2011, it has deteriorated when compared to the same period in the previous year. Information for March 2011 indicates that performance against the 12-hour component has improved with 850 patients waiting more than 12 hours in March 2011 compared to 1,239 patients in March 2010. See Figure 9.

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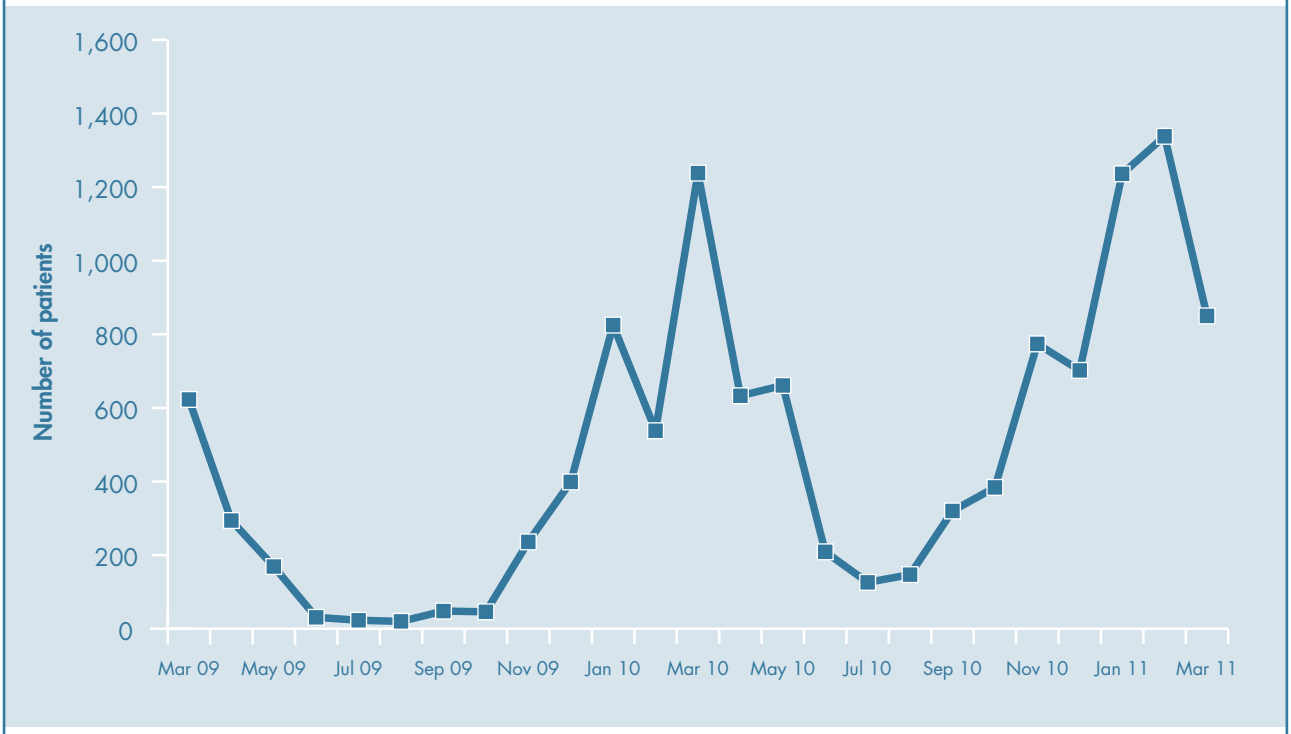
Figure 9: Patients waiting longer than 12 hours



Source: DHSSPS Emergency Care Waiting Times Statistics (January – March 2011)

Review appointments

3.3.11 Review appointments are for those patients who have seen a consultant for the first time, or have been discharged following treatment from hospital and are awaiting follow-up appointments to assess their case. No specific targets are set for these appointments. Last year, there were reports that 3,000 patients, suffering from serious eye-related conditions, were facing delays of up to a year to see a consultant. In February 2011 the Department indicated that by March 2012 all such patients should be seen within the timescale determined by their clinician.

Key points

3.4.1 Key points to note are:

- Operational performance against measures such as waiting times has declined considerably since March 2009. (paragraph 3.3.2)
- Waiting time targets have not been achieved for inpatient treatment, outpatient appointments, diagnostic tests or emergency care during 2010-11. At the end of March 2011:

  - 31,909 (30 per cent) of patients had waited longer than the target nine weeks for a first outpatient appointment;
  - 17,630 patients had waited more than 13 weeks for inpatient treatment and 1,261 of them had waited more than 36 weeks; and
  - 12,043 patients were waiting longer than nine weeks for a diagnostic service or more than 13 weeks for a day case endoscopy (paragraphs 3.3.1 – 3.3.5)

- Following the backlogs of unread x-rays within the Western Trust the Department commissioned the Regulation and Quality Improvement Authority to undertake an independent review of the handling and reporting arrangements for plain x-ray radiological investigations across Northern Ireland. (paragraph 3.3.7)

- In March 2011 the number of patients waiting more than 12 hours in an emergency care department showed an improvement with 850 waiting compared to 1,239 twelve months earlier. The target is that no patients should wait more than 12 hours. (paragraphs 3.3.8 – 3.3.10)

- Delays in review appointments, for which no specific targets have been set, have been reported. The Department has indicated that by March 2012 all such patients should be seen within the timescale prescribed by their clinicians. (paragraph 3.3.11)

Section 4:
Health Service Initiatives and Challenges

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Health Service Initiatives and Challenges

4.1.1 The primary objective of all HSC initiatives should be the delivery of better quality care to patients. It is important that lessons learned from organisational changes are applied in both the HSC sector and wider public sector. Previous general health reports have commented on a number of major change programmes in the HSC sector. In this section, we discuss the progress in realising benefits from the Review of Public Administration reforms, the shared services initiative, current ICT developments and challenges of dealing with the outbreak of pandemic flu.

Review of Public Administration

4.2.1 The aim of RPA reforms for health and social care was to reduce costs, create better quality and safer service through improved governance and assurance arrangements, streamline the number of bodies, target improved health and well-being and reduce health inequalities.

4.2.2 HSC bodies were set a target of achieving £53 million in efficiency savings by 2010-11 under the RPA reforms. The first phase of the reforms took place on 1 April 2007 when five trusts were created from mergers of eighteen smaller, legacy trusts[23]. These new trusts were set a target to reduce costs by £39 million by 2010-11. For the first two years, savings were to be achieved by reducing management costs through mergers and looking at innovative ways of delivering services. By 2010-11, the Department calculates that trusts realised savings of approximately £38.1 million (£19.27 million in 2008-09, £13.62 million in 2009-10 and £5.2 million in 2010-11). The rest of the sector was originally expected to deliver savings of £14 million by 2010-11. This has since been revised downwards to £10 million with the remaining £4 million to be delivered by 2012-13 through shared services. The Department provided the following figures for achieved and forecast efficiency savings across HSC bodies. See Figure 10.

4.2.3 The second phase of the reforms took place on 1 April 2009 when four new bodies were created: the Health and Social Care Board which replaced the four existing Boards; the Public Health Agency which incorporated and built on the work of the Health Promotion Agency; the Business Services Organisation which incorporated a number of functions from the Central Services Agency and other HSC bodies and the Department; and the Patient and Client Council which replaced the existing Health and Social Services Councils. Additionally, the functions of the Mental Health Commission transferred to the Regulation and Quality Improvement Authority and the NI Medical Regional Medical Physics Agency merged with the Belfast Trust. Approximately 37 per cent (£3.88 million) of targeted savings (£10.43 million) were realised for other HSC bodies by 2009-10. The remaining £7.34 million was achieved in 2010-11 with the HSC Board, PHA, BSO and PCC ensuring their staffing structures remained within the target levels set by the Department.

23 The NI Ambulance Service HSC Trust was unaffected by the RPA restructuring.

Figure 10: Breakdown of total RPA efficiency savings calculated by the Department

	Overall Target	Achieved 2008-09	Achieved 2009-10	Achieved 2010-11	Total Achieved to date
			£ million		
Belfast HSC Trust	13.4	6.4	6.7	0.3	13.4
Northern HSC Trust	7.4	4.55	0.6	1.8	6.95
South Eastern HSC Trust	5.84	2.92	0.72	2.4	6.04
Southern HSC Trust	6.1	2.7	2.7	0.7	6.1
Western HSC Trust	6.3	2.7	2.9	-	5.6
Total trust savings	**39.04**	**19.27**	**13.62**	**5.2**	**38.09**
Other HSC bodies	10.43	0.84	3.04	7.34	11.22
Shared services	4.00	-	-	-	-
Overall total	**53.47**	**20.11**	**16.66**	**12.54**	**49.31**

Source: DHSSPS

4.2.4 The RPA benefits' realisation plan includes financial benefits, such as achievement of efficiency savings by meeting RPA reforms and CSR savings targets, and other benefits in health and social care outcomes. The Department views benefits achieved to date as including:

- five Local Commissioning Groups have been established as committees of the Health and Social Care Board to commission health and social care services that address the needs of their local populations;
- development of an annual Commissioning Plan by the Board in full consultation with the PHA which outlines how the HSC organisations plan to respond to the needs of the population and deliver on the key priorities, standards or targets set by the Department for the HSC sector;
- the establishment of new structures and processes in PHA that facilitate joint working with local government. This has also enabled regional approaches for improving long-term health and well-being and tackling health

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inequalities to be developed and embedded across the region;

- the establishment of a Patient and Client Council responsible for ensuring a strong patient and client voice at both regional and local level, for strengthening public involvement in decisions about health and social care services and for providing assistance to individuals making a complaint relating to health and social care;

- the development of a range of systems and processes by BSO that focus on customer service, to ensure effective and consistent delivery of support services to HSC organisations; and

- the reduction in the number of HSC bodies from 38 to 17. By March 2011 administrative staff posts had been reduced by 1,698. The target reduction for March 2011 was 1,300 administrative staff.

4.2.5 The aims for RPA reforms must also be considered in the context of their impact on the control environment within the individual bodies. Ongoing measures to reduce staff numbers and pressures to realise efficiency savings could lead to the weakening of controls or to their removal. This may increase the risk of poor practice, result in mistakes being made, and increase the risk of fraud. One of the recommendations arising from the Public Inquiry into the Outbreak of Clostridium Difficile in Northern Trust Hospitals[24] illustrates this point. The Inquiry acknowledged that "the experience of staff, especially the senior managers of the Trust, during the outbreak was one of stress due to the underdevelopment of the policies, processes, responsibilities and accountabilities of the newly formed organisation, together with a deficiency of resources, both financial and of personnel."

4.2.6 It went on to recommend that: "organisational change should be recognised by the DHSSPS as carrying high risk for patient safety and quality of care, including the potential for a sub-optimal response to an outbreak of a healthcare associated infection. At such times of change, this risk should be addressed specifically and reported in the risk register of all trusts."

4.2.7 Following the publication of the report the Chief Medical Officer (CMO) wrote to the Chief Executives of all HSC trusts, the Public Health Agency and the Health and Social Care Board highlighting the Inquiry's findings and recommendations and instructing the trusts to set timeframes, with the Board, for the implementation of the recommendations addressed to the trusts. The CMO advised the trusts to recognise the risk that organisational change can impact on patient safety and the quality of care, specifically in relation to the prevention and control of infections and potential outbreaks, and to ensure that trust risk registers included appropriate action to manage or mitigate this risk.

24 The final report of the Public Inquiry into the Outbreak of Clostridium Difficile in Northern Trust Hospitals is available to download from the Inquiry website at www.cdiffinquiry.org/inquiry-report.htm

Shared Services Initiative

4.3.1 The BSO currently uses over 35 business systems to deliver its services. Many of these systems are more than 20 years old and have had minimal investment to modernise them. The risks of continuing with these systems include poor performance as a result of incremental add-ons, third party suppliers deciding that it is no longer commercially viable to support them and significant staff input and knowledge being lost through staff moving on. At the same time the cost of maintaining these systems continues to rise. Despite the extensive period over which these systems have been in place, system design and use has not been formally documented in all cases. It is reassuring to note that risk assessments completed by BSO have concluded that the historic failure rate of these systems is very low. However, given the reasons outlined above, there is an urgent need for the HSC sector to have modern systems that can provide up to date information and be accessed quickly. This is clearly illustrated by the fact that the Northern Ireland trusts collectively spend approximately £3 billion a year but compile creditors' listings manually.

4.3.2 The BSO was established to provide support services to the HSC sector to allow them to concentrate on delivery of their core objectives. Now that the organisation has been established, their next focus is the development of a range of shared services through the Business Services Transformation Programme which currently comprises the following projects:

- the procurement and implementation of human resources, payroll, travelling expenses, finance, procurement and logistics systems for the whole of the HSC sector;
- the replacement of systems for the payment of contractors within family practitioner services; and
- the identification of locations for shared services centres and the commissioning of such centres.

4.3.3 A 2006 report[25] commented on the significant progress made in implementing shared services in the health sector through the NHS Shared Business Service in England. 108 health trusts were reported to have saved an average of 34 per cent of the cost of processing finance transactions. Savings of more than £220 million over ten years are expected to be delivered in the NHS. In Northern Ireland the Department anticipates that the amalgamation of trusts, investment in new systems and the establishment of shared service organisations in the HSC sector will reduce staff posts by some 400 and provide annual savings of £8 million. A range of non-monetary benefits have also been identified, for example, improving resource management and reporting of financial information.

4.3.4 Implementation of the Business Services Transformation Programme is expected to take approximately two years. It is anticipated to cost £40 million over a 12 year period with revenue savings amounting to over £165 million across

25 Transformational Government, Enabled by Technology, Annual Report 2006 Cm 6970, January 2007

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the same period. Preferred bidders for the human resources and payroll, finance, procurement and logistics business systems have already been identified and the BSO has now completed procurement of these systems. In addition, the business case for replacement practitioner payment systems has been submitted to the Department for approval. The challenge arising from delivery of such a significant change agenda should not be underestimated. Strong leadership and substantial capital investment in systems and new accommodation will be crucial to the delivery of these developments.

ICT developments in the HSC sector

4.4.1 ICT expenditure in Northern Ireland is currently one per cent of total HSC spending but is growing. The Department advised the Health Committee[26] that the design, procurement and installation of all ICT systems needed investment of over £400 million during the next few years. The Board is now responsible for ICT planning across the HSC sector with the BSO responsible for development, support of regional infrastructure and systems and delivery of ICT services. There has clearly been a legacy of underspend within the HSC sector in Northern Ireland in ICT when compared to England and the Department needs to ensure it secures maximum value for money from the significant amount required to be invested. Current financial constraints may lead to the gap being widened further. Strategic investment at this stage will undoubtedly impact on realisation of future savings.

4.4.2 After the first wave of RPA, the single highest ICT priority across the HSC sector is to modernise and improve the basic ICT infrastructure before procuring new systems or providing new services. Since then, over £38 million of capital has been invested in ICT on projects aimed at enhancing trust infrastructure and software licences. This includes 14,500 new Personal Computers and investment in back-up technology and software and network upgrades. This investment has led to less disruption of services and more automated support.

4.4.3 New systems and services introduced in recent years include:

- all General Practitioner (GP) practices now having broadband links to the HSC network;
- a new infrastructure where individual Health and Care Numbers are used as unique patient identifiers;
- the implementation of a regional core Theatre Management System. This provides, among other things, a theatre scheduler and information to address concerns raised by us previously[27]; and
- the establishment of a regional data warehouse to support performance management.

4.4.4 A number of new systems and services are currently at implementation stage with many more planned and contractually committed. Progress is also being made

26 Committee for Health, Social Services and Public Safety, 20 May 2010
27 The Use of Operating Theatres, HC 552 and NIA 111/02, 10 April 2003

in improvements in patient care through the use of connected technology. It is recognised that to provide a modern service, the HSC sector needs to be at the forefront of innovation and new developments, however this requires considerable investment.

Pandemic Influenza Planning and the response to the H1N1 2009 pandemic

4.5.1 In Northern Ireland, the Department develops and maintains its pandemic contingency plan in conjunction with the rest of the United Kingdom. This plan recognises the need to respond quickly, to adopt an integrated and consistent approach, to ensure efforts are proportionate to the likely severity of the threat and base decisions on the best available evidence. During 2009-10 the World Health Organisation declared the world wide outbreak of a new form of influenza (H1N1 2009, commonly known as swine flu) to be a pandemic. Although this influenza pandemic turned out to cause disease of moderate severity this only became apparent after some time. Responsibilities for dealing with such emergencies in health are as follows:

- DHSSPS is the lead government department for responding to the health consequences of emergencies, such as an influenza pandemic;
- the PHA is responsible for health protection, including emergency preparedness and working closely with the HSC Board;
- the trusts are responsible for having robust emergency preparedness plans in place; and
- the BSO is responsible for storage of non-pharmaceutical products and some local procurement.

4.5.2 The Department initiated several measures to minimise the outbreak in Northern Ireland. Measures included the creation of a 24-hour swine flu helpline, the purchase and provision of swine flu vaccines, production and distribution of information leaflets and a series of advertising campaigns. The costs of managing the pandemic were £41.8 million in 2009-10. The expenditure covered clinical countermeasures such as vaccines, antiviral drugs and personal protective equipment. Around £20 million was spent on the purchase of clinical countermeasures. As part of the vaccination programme a UK wide decision was taken for GPs to receive £5.25 per dose, as well as some lessening of their primary care requirements, to reflect the additional workload required.

4.5.3 In July 2010, Dame Deirdre Hine concluded in her independent review[28], commissioned by the four UK Health Ministers, that the UK response to swine flu was proportionate and effective. The Hine Report identified improvements for future pandemic planning. Recommendations included ensuring proportionality of response in line with the perceived level of risk, use of 'break clauses' in contracts with pharmaceutical

28 The 2009 Influenza Pandemic: An independent review of the UK response to the 2009 influenza pandemic, Dame Deirdre Hine, July 2010.

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companies for flu vaccines and to build on and strengthen the arrangements in place to maintain an effective approach across the 4 UK health nations.

4.5.4 Priorities for Action set a target of March 2011 by which all relevant HSC organisations should have reviewed, tested and updated their emergency plans, including building on lessons learned from recent incidents, exercises and the response to swine flu together with any regional and national developments to pandemic flu preparedness. This target has been achieved by HSC trusts.

Key points

4.6.1 Key points to note are:

- The primary objective of all HSC initiatives should be the delivery of better quality care to patients. It is important that lessons learnt from organisational changes are applied in both the health sector and the wider public sector. (paragraph 4.1.1)

- Under RPA reforms, HSC organisations were set a target of achieving £53 million in efficiency savings by 2010-11. The Department has calculated that £49 million has been delivered with the remaining £4 million to be achieved by 2012-13 through shared services. (paragraph 4.2.2)

- The recent Public Inquiry into the Clostridium Difficile infection in Northern Trust Hospitals recognised the additional risk to patient safety and quality of care arising at times of organisational change. Measures to improve efficiency must be considered in the context of their impact on the control environment. (paragraphs 4.2.5-4.2.7)

- Many of the business systems used in the HSC sector are more than 20 years old. The cost of maintaining the existing financial systems continues to rise alongside the increasing risk of systems failures. Efficiencies can be realised across the HSC sector through the Business Services Transformation Programme and will require considerable long-term investment. Northern Ireland trusts spend over £3 billion a year but manually collate creditors. (paragraphs 4.3.1-4.3.4)

- The Department needs to ensure it secures maximum value for money from the significant ICT investment in the HSC sector planned over the next few years. (paragraph 4.4.1)

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Background

5.1.1 In 2009-10, the Department and its arm's length bodies incurred £673 million (29 per cent)[29] of the total procurement expenditure across central government departments. This expenditure increased to £750 million in 2010-11. Two Centres of Procurement Expertise (CoPEs) provide services specifically to the HSC sector; the Health Estates Investment Group and the BSO's Procurement and Logistics Service (PaLS).[30] The former manages major capital works on behalf of HSC bodies while the latter provides contracting, procurement and logistics services to HSC bodies in all key areas of their operations except for estates and pharmacy procurement. The total expenditure processed through BSO PaLS was in the region of £390 million and £460 million in 2009-10 and 2010-11 respectively. In 2009-10, BSO PaLS was heavily involved in dealing with the flu pandemic and co-ordinated receipt and distribution of personal protective equipment to health workers as well as managing distribution of consumables supporting the vaccination programme.

5.1.2 This section of the report looks at procurement issues identified during audits of HSC bodies, a recent procurement contract that was brought to our attention and briefly at procurement issues identified in the McKinsey Report[31].

Procurement issues arising from the audits of the 2009-10 and 2010-2011 accounts

Weaknesses in contract expenditure controls in 2010-11

5.2.1 During 2010-11 the non-regional trusts' Internal Audit service limited the assurance provided to the respective Accounting Officers on procurement and contract management issues. These reports identified a number of control weaknesses in relation to various contract areas, for example, contracts for service and maintenance, equipment management, social care procurement and the independent and voluntary sector and also, for three of the trusts,[32] deficiencies in respect of agency and locum expenditure. Issues identified across the trusts include:

- the use of single tenders that were not appropriately authorised;
- rolling forward of contracts without appropriate levels of management authorisation;
- use of contracts past their expiry date;
- weaknesses in monitoring of contracts in terms of checking prices to the agreed contract and ensuring service delivery is in line with the contract;
- absence of, or weaknesses in, formal policies and procedures;
- non-compliance with policies and procedures; and

29 Central Procurement Directorate: Annual Report to the Procurement Board 2009-10
30 Formerly the Regional Supplies Service in the Central Services Agency
31 Reshaping the System: Implications for Northern Ireland's Health and Social Care Services of the 2010 Spending Review (2010)
32 Belfast, Northern and Western HSC Trusts

- inadequate information systems to support contracts and deficiencies in contract documentation.

5.2.2 It is recognised that the HSC sector has undergone significant organisational change and consequently a number of these issues have arisen from arrangements that operated in the trusts merged to form the current non-regional trusts. However, these issues continue to occur across the health sector four years after these trusts came into existence. Consequently we decided to report on the matter in the 2010-11 financial statements of each non-regional trust.

5.2.3 As noted in paragraph 5.1.1, the non-capital element of HSC procurement is mainly completed through BSO PaLS. Findings reported by Internal Audit did not relate to this element of procurement.

5.2.4 The trusts have accepted Internal Audit's recommendations to improve contract management controls and are addressing them. With the potential regularity and litigation risks associated with poor contract management, added to the potential value for money rewards arising from improvement, the trusts must address these weaknesses as a priority. We plan to undertake a review of contract management procedures within the HSC sector. We will also consider the impact of any follow–up work completed by Internal Audit when examining the trust's financial statements next year and in particular the position of the security contract in Belfast Trust, referred to in Section 2.

5.2.5 Trusts have contracts in place with a number of external agencies, through the BSO, for the supply of locum doctors[33]. We reported on the use of locum doctors by Northern Ireland hospitals on 1 July 2011.

Use of Single Tender Actions (STAs)

5.3.1 Guidance to HSC bodies enables them to opt out of the normal procurement processes and adopt a single tender action where a sound business case can be made for taking this approach. Generally, this is due to a preference for a particular brand or model of equipment to ensure compatibility with existing equipment or to standardise clinical devices, for example, infusion pumps used by a variety of staff to administer fluids to patients. Where the procurement transaction is handled by BSO PaLS and a single tender action is deemed necessary, a specific form (commonly called the SS50) will be used. This form then needs to be authorised by either the Chief Executive or Director of Finance to justify and approve this method of procurement. The BSO collate information on the use of STAs across the HSC sector every year.

5.3.2 Clearly, for value for money reasons, the use of STAs should be limited to cases where it is absolutely necessary. We examined the level of usage of STAs by HSC bodies in the five years ending 2010-11. While the use of STAs across the HSC sector reduced from £9.8 million in 2006-07 to £4.2 million in 2009-10, and this is a welcome development, these

33 Locums are doctors of any grade or specialty who provide temporary staffing cover at any time and play an important role in ensuring hospitals maintain services.

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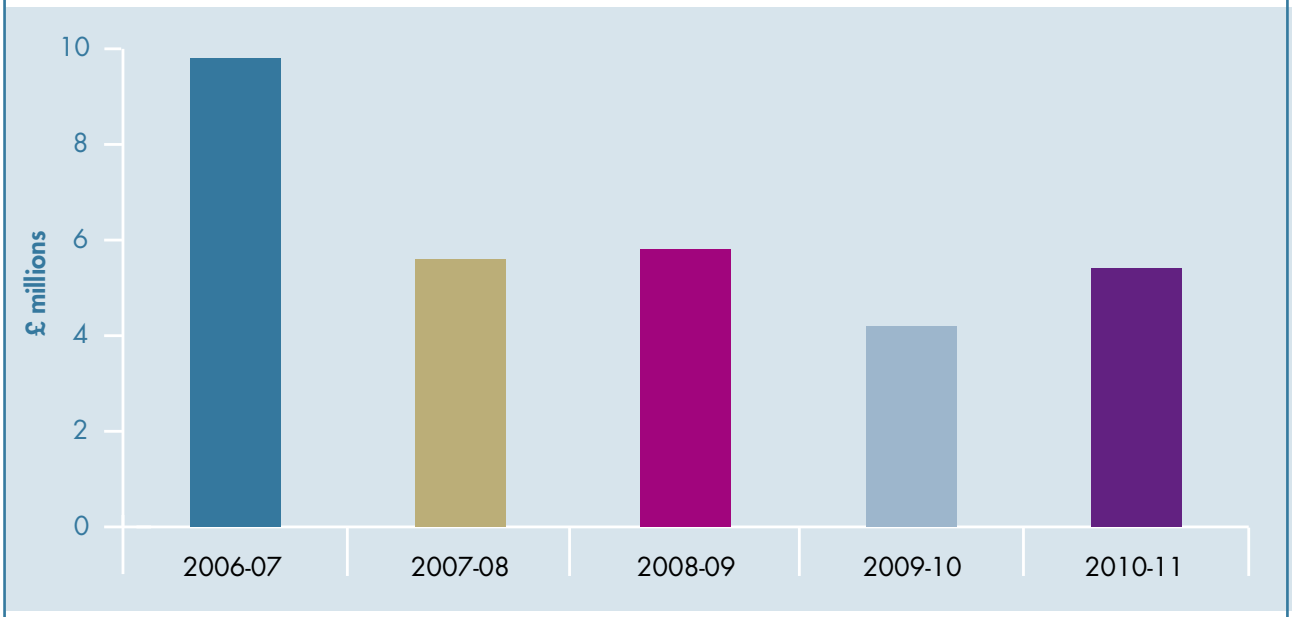
Figure 11: Use of STAs by value in HSC bodies 2006-07 to 2010-11



Source: Business Services Organisation

levels increased by 29 per cent to £5.4 million in 2010-11. Overall, there has been a marked decrease of 57 per cent by number and 44 per cent by value on equipment ordered outside of the normal procurement procedures. See Figure 11.

5.3.3 Unsurprisingly, the largest users of STAs are the five non-regional trusts. It is disappointing that three of the trusts increased their usage of STAs significantly (75 per cent increase in Western Trust, 59 per cent increase in South Eastern Trust and 43 per cent increase in Belfast Trust) in 2010-11 when compared to 2009-10.

5.3.4 We reported previously that the Southern Trust recorded the biggest spend of £2.26 million in this area in 2007-08. By 2009-10 usage had reduced by £1.66 million to £0.6 million and in 2010-11 reduced further to £0.3 million. We commend the efforts of the Southern Trust and the BSO in achieving this significant reduction. Trust expenditure on STAs over the past three years is set out in Figure 12.

5.3.5 We encourage those trusts with significant usage to focus closely on the reasons behind this. Every attempt should be made to keep usage of STAs to a minimum. The Department tells us that this issue is being examined in the context of

Figure 12: STA expenditure by HSC Trust 2008-11

Source: Business Services Organisation

its current review of procurement practice, and that it expects to put in place new procedures governing recourse to STAs. We will continue to monitor this category of expenditure.

Pharmaceutical Contracting

5.3.6 Pharmaceutical contracting in 2010-11 cost just over £110 million (2009-10: over £90 million) and mostly covers medicine and dressings for hospitals. While BSO PaLS is responsible for managing these tenders, evaluation is the responsibility of the Regional Pharmaceutical Contracting Executive Group (RPCEG)[34], which consists of representatives from each non-regional trust and the HSC Board, and is chaired by the Chief Pharmaceutical Officer.

5.3.7 Internal Audit noted that due to delays in the evaluation of these tenders, a significant number of existing contracts have had to be continuously extended outside the stipulated contract period, from periods of six months to two years. As a result, BSO PaLS has had to enter into price negotiations with suppliers which has led to increases in prices. BSO PaLS has previously advised the RPCEG of the risks associated with contract extensions.

5.3.8 By extending contracts in this way Internal Audit observed that the BSO was in breach of procurement best practice. Trusts, as the contracting authorities, risk heavy fines from penalties and damages if a legal challenge is successful. In addition, in respect of the contracts affected, it cannot be guaranteed that the HSC sector continues to achieve

34 A group of officers responsible for the strategic management of the procurement and supplies of pharmaceuticals within Northern Ireland and authorised to make contracting decisions on such procurements in the secondary care sector.

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best value for money as the competitive edge has been reduced in an area of significant procurement. The Department has told us that BSO PaLS is working to close off such extensions and avoid their recurrence however procurements may occasionally run into unforeseen circumstances, for example, a legal challenge. We note that the BSO cannot solve this issue by itself and that discussion with the Department and HSC trusts is required. All parties must work closely to resolve the bottleneck that has built up in this area. The Department tells us that this issue is being examined in the context of its current review of procurement practice, and that it expects to put in place new procedures governing contract extensions.

Unapproved committed expenditure in 2009-10

5.3.9 In our report on the financial statements of the Belfast HSC Trust we reported on the circumstances surrounding DFP's decision that the commitment of £36.14 million of the additional expenditure for the Royal Victoria Hospital Redevelopment – Phase 2B project was irregular.

5.3.10 DFP approved a business case for the project in September 2005 at an estimated cost of £98 million. By the time the construction contract was signed in July 2008, costs had increased by approximately 50 per cent to £144 million, due mainly to inflation. Approval for the additional costs was not sought from DFP until February 2010.

5.3.11 DFP took the view that expenditure exceeding the £98 million approved plus ten per cent, should not have been committed to without its prior approval and withheld its approval for expenditure above this limit.

5.3.12 In June 2010 the Minister instigated a review of the top three floors of the proposed building to ensure the best clinical use of this accommodation, in terms of addressing the areas of highest need. As a result of the review, a business case was prepared covering completion of the Phase 2B project prior to expenditure exceeding the approved level. This business case included proposals to locate part of the new women's hospital in the new critical care building and to locate postnatal beds and outpatient services on the top three floors of the critical care building; the proposal includes a new build which will house the remaining maternity services including delivery theatres, birthing rooms, antenatal services and neonatology.

5.3.13 The revised business case was submitted to DFP for appraisal on 9 February 2011. The total project costs for the new project are £200.7 million including the £98 million original approval for Phase 2B. DFP approval for the total project cost was received on 16 March 2011.

Review of HSC Laboratory Contracts

Contracts awarded in 2004

5.4.1 In 2004, laboratory contracts were procured and awarded by Altnagelvin Hospitals Health & Social Services Trust and Sperrin Lakeland Health & Social Services Trust[35] (now part of the Western HSC Trust) and Craigavon Area Hospital Health & Social Services Trust[36] (now part of the Southern HSC Trust).

5.4.2 In late 2009, an unsuccessful supplier raised concerns about the award of these contracts, specifically in relation to the difference in predicted value of the contract (at the time of tender) and the actual cost of the contracts. The suggestion was that "low-balling" had taken place, a strategy in which a supplier submits a very low bid with the intention to seek to inflate prices after the contract has been awarded.

5.4.3 Subsequently, a review was jointly commissioned by the BSO and the Western and Southern HSC Trusts. It was completed by the BSO's Internal Audit Service with specialist input from the NHS Wales Procurement Organisation. The review found that the contract value had increased mainly because:

- poor quality activity projections, based on out of date information, had been used in the original tender specification;
- in the case of the Western Trust contract, an existing contract to supply specific tests had been rolled into the new one when it expired; and
- in the case of both contracts the unit costs per test specified in the successful tender bids were implemented and then increased by an inflationary uplift each year.

5.4.4 The Internal Audit review concluded that while neither contract was consistently and effectively monitored both contracts had been tendered in line with EU procurement regulations in force at the time. The weaknesses in contract tendering and management identified during the review have led to a range of recommendations being issued for future contracts. For example,

- tender options and their makeup must be clearly specified in tender documentation and be consistent throughout it;
- where a decision is made to alter the financial basis on which the contract is based, this must be done formally through a contract variation and the authorisation of the trust;
- tender evaluations must be evaluated on a similar and comparable basis;
- usage data must be as accurate as possible at the point that the tender is issued;
- the Evaluation of Offers from Suppliers must be signed off by the trust prior to the Letter of Award being issued; and

35 On 31 March 2007, Foyle HSS Trust merged with Altnagelvin Hospitals HSS Trust and Sperrin Lakeland HSS Trust to form the Western Health and Social Care Trust.

36 On 31 March 2007, Craigavon Area Hospitals Group HSS Trust merged with Armagh & Dungannon HSS Trust, Craigavon & Banbridge Community HSS Trust and Newry & Mourne HSS Trust to form the Southern Health and Social Care Trust.

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- all clarifications must be kept to an absolute minimum. In the event they are required, they must be managed in a controlled and formal manner.

5.4.5 The Department has informed us that the BSO has addressed those recommendations directed to them within a new regional laboratory contract which was tendered and awarded during 2010-11.

Procurement issues identified in the McKinsey Report

5.5.1 The McKinsey Report recognises the potential for procurement savings in the HSC sector and we will look at this in our forward work programme. Opportunities for reducing the unit cost of care include:

- optimising prescribing and procurement of pharmacy, through increasing the use of generic drugs and therapeutic substitutes, better negotiation during procurement and introducing clear clinical protocols on prescribing;

- optimising procurement of other supplies through reviewing standards for the products used, reducing waste, and consolidating spend on fewer product variations and a smaller number of suppliers to get the best price;

- improving management of patient flows to and from other regions through more cost-effective procurement of services provided outside of Northern Ireland (for example, eating disorder services) and better management of two-way reimbursement for patients who cross the border (in either direction) with the Republic of Ireland for treatment; and

- renegotiating unit prices or re-procuring services – for example, services provided by third parties within Northern Ireland – primarily private nursing home care and family health services practices.

5.5.2 In agreeing the final budget allocations for the Department, the Northern Ireland Executive agreed that the Performance, Efficiency and Delivery Unit (PEDU) would be commissioned to provide support to the Department in the delivery of savings. The Department has advised that the PEDU review is intended to draw heavily on the McKinsey Report and will not only focus on 2011-12 savings but also on the need and scope for strategic change to provide more effective service delivery.

Key points

5. 6.1 Key points to note are:

- The Department and HSC bodies procured expenditure of £673 million in 2009-10 and £750 million in 2010-11. (paragraph 5.1.1)

- In 2010-11, we reported on the financial statements of each of

the non-regional trust's regarding weaknesses in contract expenditure controls and trusts are addressing the weaknesses. With the potential regularity and litigation risks associated with poor contract management, added to the potential value for money rewards arising from improvement, the trusts must address these weaknesses as a priority. (paragraphs 5.2.1 – 5.2.4)

- The use of Single Tender Actions across the HSC sector has reduced from £9.8 million in 2006-07 to £5.4 million in 2010-11 and this is a welcome development. (paragraph 5.3.2)

- Weaknesses in laboratory contract tendering and management procedures have been identified in a recent review by Internal Audit. A range of recommendations have been issued for future HSC contracts. (paragraph 5.4.4)

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