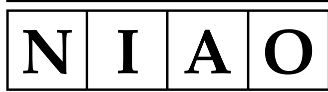
General Report on the Health and Social Care Sector by the Comptroller and Auditor General for Northern Ireland - 2009

REPORT BY THE COMPTROLLER AND AUDITOR GENERAL
30 June 2010



Report by the Comptroller and Auditor General for Northern Ireland

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K J Donnelly
Comptroller and Auditor General

Northern Ireland Audit Office
30 June 2010

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For further information about the Northern Ireland Audit Office please contact:

Northern Ireland Audit Office
106 University Street
BELFAST
BT7 1EU

Tel: 028 9025 1100
email: info@niauditoffice.gov.uk
website: **www.niauditoffice.gov.uk**

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Abbreviations

AfC	Agenda for Change
BAFO	Best and Final Offer
BHSCT	Belfast Health and Social Care Trust
BSO	Business Services Organisation
C&AG	Comptroller and Auditor General
CFU	Counter Fraud Unit
CRL	Capital Resource Limit
CSA	Central Services Agency
CTF	Charitable Trust Fund
DHSSPS	Department of Health, Social Services and Public Safety
DFP	Department of Finance and Personnel
EPES	Electronic Prescribing and Eligibility System
EPF	Executive Programme Funds
GMS	General Medical Services
GP	General Practitioner
HSC	Health and Social Care
HSCB	Health and Social Care Board
HPSS	Health and Personal Social Services
ICT	Information Communication Technology
KSF	Knowledge and Skills Framework
MHRA	Medicines and Healthcare products Regulatory Agency
MRSA	Methicillin-Resistant Staphylococcus Aureus
NAO	National Audit Office
NDPB	Non-Departmental Public Body
NHS	National Health Service
NIAO	Northern Ireland Audit Office
NIAS	Northern Ireland Ambulance Service Trust
NIBTS	Northern Ireland Blood Transfusion Service
NPfIT	National Programme for IT
OGC	Office of Government Commerce
PAC	Public Accounts Committee

Abbreviations

PCC	Patient and Client Council
PCIS	Person-Centred Community Information System
PFI/PPP	Private Finance Initiative/Public Private Partnership
PHA	Public Health Agency
PPE	Post Project Evaluation
PSA	Public Service Agreement
RSS	Regional Supplies Service
RPA	Review of Public Administration
RQIA	Regulation and Quality Improvement Authority

Part One:
Introduction

Part One: Introduction

Background

1.1.1 The financial audit of the accounts of the bodies comprising the Health and Social Care (HSC) sector in Northern Ireland became the responsibility of the Comptroller and Auditor General for Northern Ireland (C&AG) from 1 April 2003. In June 2009 the C&AG published the second General Report on the Health and Social Care Sector, looking principally at the results of the 2007-08 accounts audits, but also considering some of the important issues identified in the 2005-06 and 2006-07 audits.

1.1.2 This report focuses on the results of the 2008-09 audits and also looks back to issues raised in 2007-08.

The Scope of the Audit and this Report

1.2.1 The report covers the audits of 16 health bodies. These include all health and social services boards (the boards), all health and social care trusts (the trusts) and a number of agencies and special agencies established by the Department of Health, Social Services and Public Safety (the agencies). It does not cover the results of the audit of the Department of Health, Social Services and Public Safety (DHSSPS/the Department). A full list of the bodies covered is shown at Figure 1.

1.2.2 Health service audit is carried out under statute by staff from the Northern Ireland Audit Office (NIAO), although a significant amount of work is contracted out to the private sector. The work of the private sector firms is completed to NIAO quality standards and the audit certificates are signed by the Comptroller and Auditor General. Quality control is maintained by approving the plans of contractor firms before audit work commences, regular monitoring of the progress of audits and by quality assurance reviews of the completed audit work by Audit Office staff before the C&AG signs the certificate.

Figure 1: Bodies in the Health and Social Care Sector 2008-09 Covered by this Report

Trusts
Belfast Health & Social Care Trust Northern Health & Social Care Trust South Eastern Health & Social Care Trust Southern Health & Social Care Trust Western Health & Social Care Trust NI Ambulance Service Health & Social Care Trust
Boards
Eastern Health & Social Services Board Northern Health & Social Services Board Southern Health & Social Services Board Western Health & Social Services Board
Agencies
NI Blood Transfusion Service NI Central Services Agency NI Guardian Ad Litem Agency NI Health Promotion Agency NI Medical and Dental Training Agency NI Regional Medical Physics Agency

Overall conclusion

1.3.1 It is becoming apparent that, in the context of delivering health and social care, the sector's performance has undergone a step change improvement in recent years. On measures such as waiting times, prevention of and mortality from heart disease and cancer, the HSC sector is delivering a markedly better service than five years ago. With the implementation of revised structures under the Review of Public Administration (RPA), new pay regimes for health and social care professionals and staff and a considerable capital investment in the health estate, the building blocks for making and sustaining further progress are being established.

1.3.2 The financial stability of trusts is coming under increased pressure and this has the potential to affect the HSC sector's performance on some key targets. In addition, the required HSC response to swine 'flu and the need to hold back funding to offset outstanding deficits may also adversely impact upon progress to date and the ongoing achievement of its objectives. For example, a range of service developments have been necessarily delayed in the short term (including bowel cancer screening and some services for people with long-term health conditions such as stroke and heart disease). The Minister has also highlighted that further progress in reducing waiting times in Accident and Emergency and incidences of healthcare related infections is necessary. The challenge of embedding good governance - in all aspects of the HSC sector's work - remains ever present.

1.3.3 Realising the benefits of major change programmes of recent years is an important challenge for the health and social care sector. Progress has been achieved, undoubtedly, but direct evidence of the contribution to this made by, for example, RPA and the Agenda for Change (AfC) is limited. The monitoring of the monetary benefits from the first phase of RPA, i.e. the reduction in the number of trusts, is fully integrated in the Department's Comprehensive Spending Review efficiency monitoring arrangements. However, both of these initiatives are still ongoing and the Department has established plans to undertake formal benefits realisation plans. We look forward to the outcomes of these. They are likely to have much to say to inform the major change process elsewhere in the public sector.

Part Two:
Performance

Part Two: Performance

2.1.1 The Department requires that health and social care 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.

2.1.2 This section provides an overview of health and social care bodies' financial and operational performance in 2008-09.

Overall financial performance

2.2.1 Trusts are required by statute to ensure that their income is sufficient to meet their expenditure taking one year with another - the break even duty[1]. An explanation must be provided in the accounts if a deficit of greater than 0.5 per cent of income arises. The Department requires that agencies and boards conform to the general requirement of good financial management and specific targets have been established for these bodies to break even each year.

2.2.2 Two trusts failed to achieve break even in 2008-09. The Northern Trust reported a deficit of £958,000 and the Belfast Trust's deficit was £511,000. However, these deficits were well within the tolerance limits of 0.5 per cent of income. The remaining trusts reported surpluses of between £38,000 and £670,000. The Western Trust achieved a surplus of £44,000 and

Figure 2: Trusts' financial outturns 2008-09 and 2007-08

Source: HSC trusts' accounts, 2008-09 and 2007-08

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

as a result, the Department confirmed that it would not be required to make good the £3.4m deficit inherited from the Sperrin Lakeland Trust at 1 April 2007.

2.2.3 A number of factors contributed to these results. All trusts experienced a significant increase in expenditure on healthcare provided by the private sector, largely as a result of the drive to meet waiting list access targets whilst at the same time responding to increasing demand for these services. The costs of utilities (gas, oil, electricity) also rose to a peak during the early part of the year. A considerable decline in income from interest on bank deposits was also experienced in 2008-09 as new arrangements, to ensure the more timely draw down of cash, were introduced by the Department in compliance with Department of Finance and Personnel (DFP) treasury management requirements. For example, this reduced the level of investment income available to the Northern Trust by £3.5m compared to 2007-08.

2.2.4 Two boards, Eastern and Southern, returned small revenue deficits in 2008-09 of £39,000 and £86,000 respectively. Each of these results was well within the tolerance limit of 0.5 per cent of turnover set by the Department. The other boards returned small surpluses. Agencies were able generally to contain their expenditure within their income this year, although the Central Services Agency returned a deficit of £66,408.

2.2.5 The HSC financial regime includes a number of other financial targets:

- the Capital Resource Limit (CRL), a fixed annual capital spending limit for each trust, set by the Department;
- the commissioning administration ceiling (commissioning cost), a statutory target for the administrative costs at each board of commissioning health and social care from providers, set by the Department as a percentage of relevant income;
- management costs, a best practice measure of trusts' efficiency. All trusts are expected to maintain their management costs[2] within a ceiling of 5 per cent of overall expenditure; and
- the prompt payment policy, a best practice measure, applies to all HSC bodies[3]. No actual target for performance is set, but best practice suggests that 95 per cent of payments to creditors should be made within 30 days.

2.2.6 Performance against these targets was generally sound. All trusts met their CRL in 2008-09, as did the agencies[4].The Department spent £204m capital, 99.8 per cent of its capital budget allocation of £204.3m. DHSSPS attributed this to its pro-active management by ensuring it made full use of and invested all of its available capital resources. Management costs were contained within the 5 per cent ceiling in five trusts, with only the Northern Ireland Ambulance Service (NIAS) returning above this figure. While it returned a figure of 6.92 per cent, the

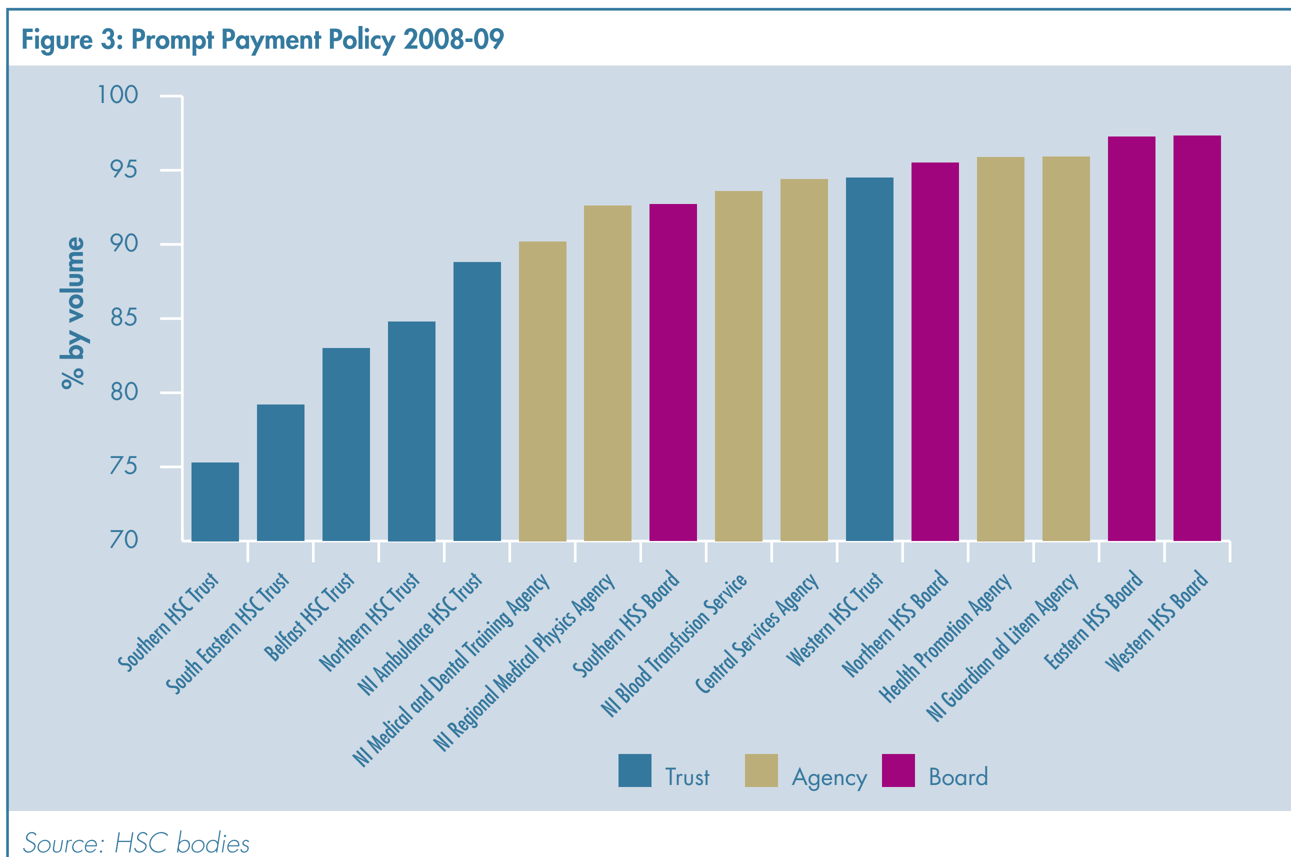
2. The calculation of management costs is based on the Audit Commission definition and reflected in Departmental guidance to trusts
3. The Department requires that all HSC bodies pay their non-HSC trade creditors in accordance with the Confederation of British Industry's Prompt Payment Code and associated Government Accounting rules, and that they disclose annually the extent to which they comply with these requirements
4. With the exception of the Guardian Ad Litem Agency which was marginally over by £404.

Part Two: Performance

Department advised that this was in accord with other ambulance trusts in the UK. NIAS shows a figure of 6.32 per cent (adjusted for capital charges to compare with other UK ambulance trusts) compared to the median of other ambulance trusts of 6.47 per cent in 2008-09. As a much smaller organisation in terms of income and employees, compliance with good governance in the Ambulance Service means that management costs are relatively higher than in larger trusts. The boards continued to focus on commissioning costs, reporting costs as a percentage of relevant income of between 0.95 per cent (in the Eastern Board) and 1.45 per cent (the Southern Board). All the boards met their commissioning costs' targets.

2.2.7 As in 2007-08, the common exception to this performance was in compliance with the prompt payment policy. Only five out of sixteen bodies – the Northern, Western and Eastern Boards, the Health Promotion Agency, and the Guardian Ad Litem Agency - achieved the 95 per cent target (see Figure 3). Nevertheless, this is an improvement on the last year's results, when only one HSC body achieved the target.

Figure 3: Prompt Payment Policy 2008-09



Source: HSC bodies

2.2.8 While some bodies came close to meeting the target – the Western Trust and the Central Services Agency both achieved above 94 per cent - the overall picture is one of average compliance at around 91 per cent, an improvement on last year's average (90 per cent). However, some bodies fell well below the target: the Southern and South Eastern trusts achieved 75.3 per cent and 79.2 per cent respectively. It is clear that HSC bodies need to remain focused on achieving the standard expected. The Department continues to monitor performance in compliance with the policy. Given these results, the DFP request to departments and agencies in November 2008, to support a ten day target for prompt payments, and to report performance against the ten-day commitment on a more frequent basis[5], presents a major challenge to the HSC sector. The Department reminded HSC bodies of their obligations on this front, in February 2010.

Operational performance

2.3.1 The sector's performance in delivering health and social care improved again in the year to 31 March 2009. The Minister's announcement in June 2009 highlighted a number of successes:

- significant improvements in waiting times for in-patient, diagnostic and outpatient treatment;
- reductions in healthcare associated infections, for example, methicillin-resistant staphylococcus aureus (MRSA);
- the resettlement of increasing numbers of long stay mental health and learning disability patients in the community; and
- the NI Ambulance Service responded to 74 per cent of Category A (life threatening) calls within 8 minutes in March 2009.

2.3.2 Maintaining this improvement could prove to be a challenge. Monitoring reports in 2009-10 show a varying position with, for example, the September 2009 quarterly results showing a decrease in the total number of people waiting for a first outpatient appointment but an increase in the number of these patients waiting over the nine weeks target. The total number of patients waiting for diagnostic services had decreased from the previous quarter, but this was still higher than the previous year and more were waiting over the maximum waiting time target. Clearly, this aspect of health sector performance will require continued attention.

2.3.3 In his June 2009 statement, the Minister also pointed to the areas where performance needs to improve further:

- further reductions in healthcare associated infections are necessary; and
- some patients still wait longer than they should for treatment. Urgent improvements in this regard are necessary in Accident & Emergency services. We reported on this subject in April 2008[6].

5. Circular DAO(DFP) 12/08, Department of Finance & Personnel, 27 November 2008
6. *Transforming Emergency Care in Northern Ireland*, NIAO, April 2008

Part Two:
Performance

Obesity & diabetes

2.3.4 We published our report, Obesity and Type 2 Diabetes in Northern Ireland in January 2009[7]. This examined what contribution the Department's investment in health promotion had made to preventing the occurrence of Type 2 diabetes.

2.3.5 The increasing levels of obesity and diabetes in Northern Ireland are of concern to the Department, and the link between the two conditions is well known and acknowledged. The need to tackle obesity through addressing lifestyle factors such as physical activity and eating habits is also well established and the Department told us that it has been part of its overall public health approach to the issue for a number of years – reflected in the work carried out in the mid-1990s in developing a physical activity strategy and work to develop a food and nutrition strategy. More recently, as the evidence base for childhood obesity has become clearer, the Department has increased the focus on tackling childhood obesity through a cross-departmental strategy *Fit Futures*[8]. A Public Service Agreement (PSA) target has also been established aimed at halting the rise in childhood obesity. There is currently one 2008-11 PSA target on obesity, performance against which is measured by two indicators:

Target: *By 2011, halt the rise in obesity.*

Indicators:

- *By 2011, stop the increase in levels of obesity among children aged 2-10;*
- *By 2011, stop the increase in levels of obesity among adults aged 16+.*

2.3.6 Following the publication in Great Britain of *Foresight – Tackling Obesities: Future Choices*[9] in October 2007, the Department adopted a strategic approach to obesity, putting in place an Obesity Prevention Steering Group, supported by four Advisory Groups addressing the issues of physical activity, food and nutrition, education and prevention, and data collection and research. These groups will take forward the *Fit Futures* recommendations and also advise the Department on the development of a strategic framework to tackle obesity across the whole of the Northern Ireland population. The Obesity Prevention Strategic Framework is planned for publication in June 2010.

2.3.7 While addressing the problem of obesity has been a Departmental priority since the mid-1990s, the full impact of its primary prevention strategies on reducing the burden of Type 2 diabetes has still to be realised. Against this background, our review looked at how health promotion activities could be strengthened in order to deliver behavioural interventions capable of providing cost-effective benefits. In addition, we found scope to improve the evidence base and the targeting and monitoring of effort.

2.3.8 The Department states that it has already begun to consider the findings within the report and is seeking to identify any areas for specific further action. As noted, there are actions in train to address what is very

7. *Obesity and Type 2 Diabetes in Northern Ireland*, NIAO, January 2009
8. *Fit Futures: Focus on Food, Activity and Young People*, Report to the Ministerial Group on Public Health, December 2005.
9. *Foresight – Tackling Obesities: Future Choices*, Government Office for Science, Department of Innovation, Universities and Skills, DIUS/2K/10/07/NP, October 2007.

much a worldwide trend in growth in both obesity and diabetes.

Financial outlook

Revenue

2.4.1 Financial pressures on HSC bodies continued to build in 2009-10. The new Health and Social Care Board (HSCB), established on 1 April 2009 following the dissolution of the four health and social services boards, played a leading role in managing resources of more than £4bn for health and social care services in 2009-10. Once again, trusts were predicting deficits throughout the early part of the year. The Belfast Trust initially forecast a £40m shortfall. After implementing contingency plans and other cost saving measures, and receiving additional income in recognition of the exceptional demand pressures in 2009-10, the Trust was again in a position to forecast break even as the year end approached. The Northern Trust was initially predicting a £14.7m deficit and by midyear, this had declined to a forecast deficit of some £29m. However, implementing contingency plans and other savings measures, and receiving further funding support has enabled the Trust also to forecast breakeven in the run-up to the 2009-10 year end. As regards the other HSC trusts the pattern in 2009-10 has been similar, if somewhat less severe, but again in all cases it is now anticipated that they can achieve effective break even in 2009-10.

2.4.2 In the light of the indications of threatened shortfalls at earlier stages of the 2009-10 year, we were unable to provide positive assurances to the Department about trusts' financial standing at the conclusion of the 2008-09 audits. The Department continues to monitor closely the financial position of all HSC organisations on an ongoing basis and requires individual organisations to take corrective action where necessary in order to achieve the mandatory break even target. As indicated above, significant progress has been made in resolving the financial position for 2009-10, and it now appears that the necessary overall financial balance will be regained by the end of the year. Going forward into 2010-11, the challenge will be to balance financial resources with the need for continual improvement in performance, while at the same time responding to ever increasing demands for services.

2.4.3 During 2009-10 the World Health Organisation declared the world wide outbreak of swine 'flu to be a pandemic, albeit of moderate severity. Its impact in Northern Ireland rolled out through 2009-10 with a phased vaccination programme for vulnerable groups. By February 2010, the Minister declared that around 327,000 people had been vaccinated, and although swine flu had contributed to the deaths of 18 people in Northern Ireland, the virus was by then circulating much less widely in the community. Nevertheless, it was recognised that any significant outbreak would place considerable pressure on healthcare resources. With the estimated 2009-10 costs revised to some £44m as at February 2010, plans have been

Part Two: Performance

reformulated. The Department continues to recognise swine flu and other pandemic threats as a major risk factor in its financial planning.

Capital

2.4.4 The Investment Strategy for Northern Ireland earmarked £728m to be spent on improving primary care and hospital modernisation against a £1.1bn bid for resources. The £728m included assumed annual income from disposal of surplus assets totalling £95m. Failure to achieve this level of income effectively reduces the available capital budget. The Department advised us that the economic downturn and the impact on the local property market has rendered the £95m unattainable and it revised its estimate to £45m. This means that the available budget has been cut to £678m. These funds will modernise and reform health infrastructure and help to transform health and social care delivery by providing more treatment and care in local, community based settings, reducing the need for hospital admissions. At the same time, investment in a series of core acute hospitals across the region, and in local hospitals, has begun to modernise an estate which, in many cases, dates from the late 19th and early 20th centuries.

2.4.5 To this end, the Department invested more than £204m in 2008-09 on a range of schemes across the hospital and primary care sectors, including major projects such as Ulster Hospital Redevelopment Phase A, Downe Enhanced Local Hospital, Altnagelvin Area Hospital Redevelopment and the Royal Victoria Hospital Phase 2B Critical Care Building. A further £190m has been invested in 2009-10, which, in addition to the above schemes, will also enable several other priority schemes to move forward including: the Trauma & Orthopaedics Unit at Craigavon Area Hospital; Portadown Health & Social Care Centre; and Regional Adolescent and Child & Family Units at the Forster Green site. The total estimated costs of the major projects in the HSC sector are more than £1.1bn over the next ten years.

2.4.6 In working towards these goals, the strategy established a number of key milestones:

- a new local enhanced hospital at Downpatrick by 2009. This facility opened in June 2009;
- a new mental health facility at Gransha Park by 2010. Funding restraints have required this scheme to be delayed by at least two years. Design of the facility is now complete and work is in hand for the scheme to go out to tender;
- completing Phase A of the Ulster Hospital redevelopment by 2010. This project remains on schedule for completion;
- opening five new health and well-being centres by 2011 at the Grove, Castlereagh, Andersonstown, Shankill and Portadown. The Grove, Castlereagh and Portadown centres have been completed. Shankill and Andersonstown will complete by 2011;

- opening the new South West acute hospital by 2012. This PFI scheme remains on schedule for completion by the target date; and

- a new local enhanced hospital in Omagh by 2013. The Department has requested a reassessment of value for money offered by the procurement route for this scheme. Until that work is complete, it is not possible to confirm the timescale.

2.4.7 We remain engaged with the Department in reviewing technical accounting advice on PFI/PPP projects – most recently, on the South West hospital project - and in considering the value for money of the proposals. We will continue to review the progress of the HSC capital programme in the coming year.

Part Three:
Health service initiatives

Part Three: Health service initiatives

3.1.1 In our last General Report we commented upon a number of the major change programmes in the health and social care sector, including new professional contracts for consultants, GPs and health and social care staff and the continuing organisational changes arising from the Review of Public Administration (RPA). In this section, we discuss more recent developments in:

- the Review of Public Administration; and
- Agenda for Change.

Review of Public Administration

3.2.1 The latest phase of RPA in health and social care saw the establishment on 1 April 2009 of the new Health and Social Care Board (HSCB), the Business Services Organisation (BSO), the Public Health Agency (PHA) and the Patient and Client Council (PCC). These new organisations replaced and subsumed the functions of:

- the four health and social services boards;
- the Central Services Agency;
- the Health Promotion Agency; and
- the four health and social services councils.

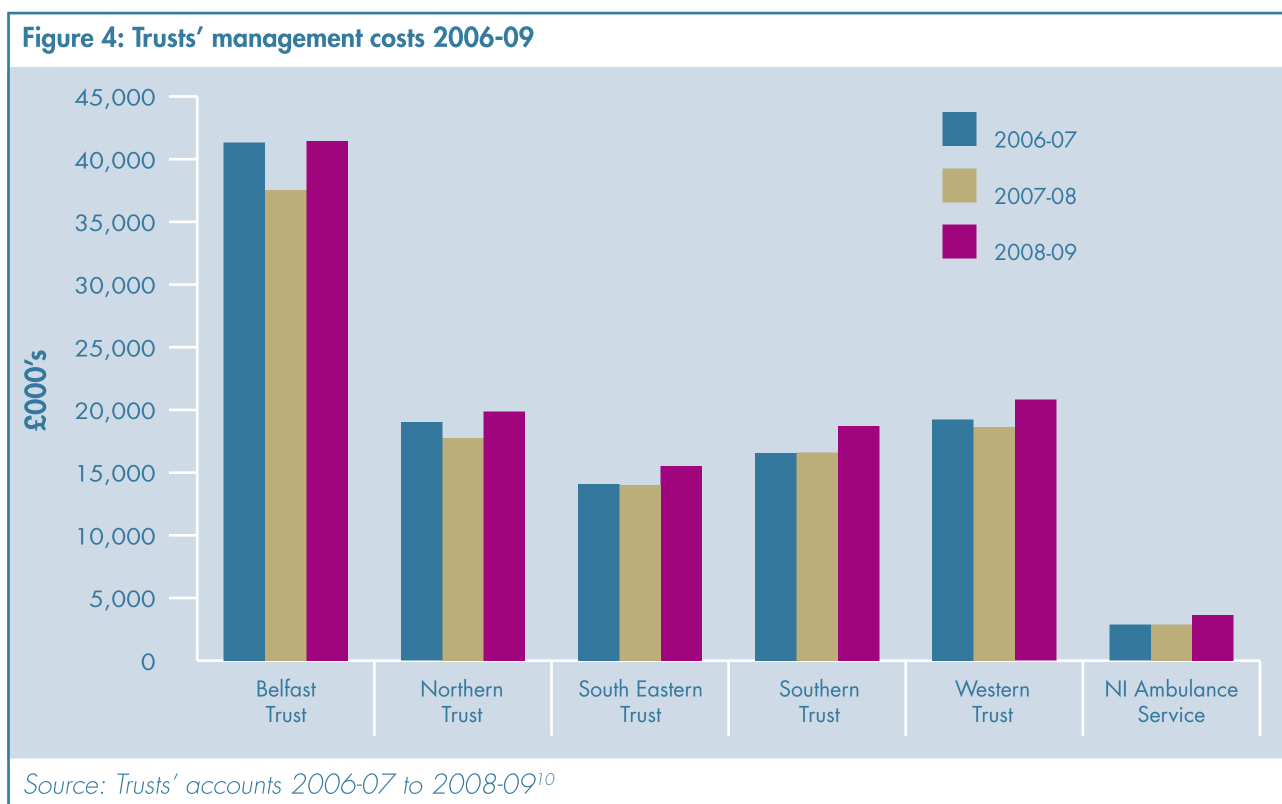
In addition, a number of functions housed formerly within the Department and the Beeches Management Centre, such as IT support and internal audit, transferred to the Business Services Organisation.

3.2.2 In our last General Report we commented upon some of the challenges faced by the organisations newly created under RPA - of integrating the diverse financial and operating systems of the predecessor organisations; of maintaining a skilled and committed workforce in a time of change and uncertainty; and of creating a unified organisational culture in the new body – and observed that the benefits of the reorganisation could take some time to emerge. Certainly, the Department does not expect that the final RPA phase will be completed until 2011. However, there are some emerging indicators.

3.2.3 The first phase of RPA in the health and social care sector created five trusts from a series of mergers of eighteen smaller, legacy trusts on 1 April 2007. The NI Ambulance Service (NIAS) was unaffected by the RPA restructuring. Amongst a range of success factors for RPA was an overall reduction in management and administration costs. Analysis of the management costs reported in the 2006-07 accounts of the nineteen legacy trusts shows a total spend of over £113m. In 2007-08, the six new trusts reported spending on management of £107.5m, a saving of £5.6m. By 2008-09 however, the trusts' management costs had risen to £120m.

3.2.4 The gains of 2007-08 disappeared in 2008-09: two years after the creation of the new trusts, their management costs had risen to exceed those of the legacy

Figure 4: Trusts' management costs 2006-09



Source: Trusts' accounts 2006-07 to 2008-09[10]

trusts by £7m in cash terms. This overall rise included some significant increases in individual bodies. Management costs in the NI Ambulance Service rose by 27 per cent and in the Southern Trust (including its legacy trusts) by 13 per cent, between 2006-07 and 2008-09. On this evidence, it remains to be seen whether the targeted RPA reductions in management costs will be achieved.

3.2.5 However, the Department has emphasised the importance of putting the increase in management costs into context, and explained that a contributing factor to the increase in 2008-09 was the large rise in employer's superannuation costs (on 1 April 2008 this increased from 7 per cent to 15.7 per cent). In addition, 2006-07 and 2008-09 saw the assimilation of managers to Agenda for Change bands. This accounted for all of the growth in the NI Ambulance Service management costs over the period. The Department asserts that when the 2006-07 management costs are rebased to 2008-09 levels factoring in inflation, Agenda for Change contracted progression and a change in employer's superannuation rate, there is a real terms savings on management costs of almost £6.7m.

3.2.6 A wider perspective of the impact of RPA is that trusts have been set a target of achieving £38m in reduced costs across their entire operations as a result

10. 2006-07 figures amalgamate the management costs of the legacy trusts which merged to form the new trusts on 1 April 2007

Part Three:
Health service initiatives

of reorganisation by 2010-11. Against an interim target in 2008-09 of £18m in efficiency savings, trusts achieved £19m. The interim cumulative target for 2009-10 is £37m, that is, trusts will need to achieve a further £18m. Overall, the HSC sector plans to deliver efficiency savings of £53m as a result of RPA by 2010-11. The savings to be delivered by the trusts are: Belfast £13.4m, South Eastern £6.4m, Southern £5.5m, Western £5.7m and Northern £7.2m. The minimum efficiencies to be delivered by 2010-11 from the RPA bodies formed on 1 April 2009 have been set as follows: HSCB £4.96m, PHA £1.96m, BSO £1.99m and PCC £0.11m, with a further £1.4m to have been decided upon in January 2010. A further £4m of savings will be delivered through the shared services organisation, the BSO.

3.2.7 These savings are not without cost. By September 2009, the cost of RPA related voluntary redundancies and voluntary early retirements on the grounds of redundancy, in the five new trusts, had exceeded £48m. The Department told us that, overall, it expects to spend £74m in this way, in bodies affected by RPA, by the time the process is complete.

3.2.8 The advent of the new bodies on 1 April 2009 creates some new challenges. In particular, the structure provides for a high degree of integration between the bodies, and with the rest of the HSC sector. The HSCB will be responsible for ensuring the effective use of £4bn to be spent on commissioning health and social care. A single integrated commissioning plan will be developed in partnership with and with the agreement of the Public Health Agency. The HSCB's Local Commissioning Groups are co-terminus with the five trusts, and aim to drive effective locality based commissioning. The HSCB will also need to work closely with the Department, trusts, the PHA and the Regulation and Quality Improvement Authority to deliver on a wide range of objectives. For its part, the BSO will provide key support services such as procurement across the HSC sector, as well as providing financial management services to a number of agencies and NDPBs. The PCC is charged with representing the interests of patients and clients in the commissioning and delivery of health and social care services. Effective partnership working by all parties will clearly be a necessity for success under these arrangements.

3.2.9 The Department's Modernisation and Improvement Programme Board has agreed a RPA benefits realisation plan to facilitate monitoring of the overall benefits anticipated by the programme. These include financial benefits and others, such as benefits in health and social care outcomes. Some of these benefits will not start to materialise until after the reforms have been implemented. It will therefore be important to maintain the benefits realisation plan beyond project delivery through to complete realisation. Also important will be mechanisms to measure specifically the achievement of the benefits identified within the plan. While some of the projected benefits include hard monitoring data, such as costs and staff numbers, others identify less specific measurements, for example

using the accountability framework to measure progress. The Department will need to ensure that it establishes robust measurement of all the benefits anticipated from RPA. It may also be useful to include stakeholders' views – those of patients, clients, staff and the wider public – in the benefits assessment process. We will monitor the Department's progress closely.

Agenda for Change

3.3.1 The Minister's announcement in June 2008 that all HSC staff had been assimilated at the new pay points was a significant milestone in the Agenda for Change (AfC) process. A UK wide initiative, AfC provided for a new pay structure for health and social care staff. Commencing in December 2004, it affected more than 60,000 HSC employees in Northern Ireland.

3.3.2 The process has been intensive. All staff either had their job matched to a benchmark job profile or where that was not possible, the job was subject to a job evaluation. Once a job was graded and checked for consistency, a transfer from the old pay system to the new system was affected. Inevitably, this took some considerable time. Even after the Minister's announcement, the process was not complete. Whenever the assimilation took place, its effective date was in October 2004: consequently, arrears of pay had to be calculated and paid. Staff appeals against their re-grading had still to be heard. In a minority of cases, re-grading resulted in staff being assimilated at pay points lower than under the old pay system and overpayments of salary had to be recovered.

3.3.3 Given the sheer scale of the exercise the progress made has been impressive, although it has taken considerably longer than envisaged. It has also not been without its problems. The internal auditors at the trusts, the largest employers in the HSC sector, have reported consistently on significant levels of error in the overpayment calculations. There are, inevitably, some unhappy employees: for example, the Northern Trust is dealing with around 600 requests (covering 2,000 employees) from staff to have their Agenda for Change grading reviewed. The recovery of overpayments has generally been pursued by HSC bodies in line with established guidance, but this has also presented difficulties.

3.3.4 At the Northern Ireland Medical and Dental Training Agency, errors in the calculation and assimilation process resulted in overpayments to staff of £22,000 in 2007-08. Ordinarily, this would not be a matter for particular concern. However, £9,000 of the overpayment was made to two senior officers responsible for the process. The Agency did not initially seek to recover the overpayments; neither did it re-assimilate staff at the correct points on the pay scale. As a consequence, the overpayments increased during 2008-09 to a total of £34,000. This matter caused us to qualify the regularity opinion and issue a report on the Agency's 2008-09 accounts. The Department has requested that the Agency makes efficiencies each

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Health service initiatives

year within its existing budget allocation to meet the overpayment incurred. This will be a reducing figure as individuals reach their correct pay point over time.

3.3.5 A key part of AfC is a process for encouraging staff development and improving staff performance known as the Knowledge and Skills Framework (KSF). With the emphasis upon the assimilation process, progress in establishing the KSF has, so far, lagged behind. It was intended that all HSC staff should receive an annual performance review under the KSF, with its associated personal development plan. For most staff, this is not yet a reality. There is an intention within the AfC regional joint working group (including representatives from the Department, HSC employers and the trade unions) to focus on the full implementation of the KSF in 2009-10. With this in mind, the Department launched the Regional Learning and Development Strategy in April 2009. It will be important to support this with detailed action plans to deliver the resources necessary for success, for example, training needs assessments, the associated IT structure and funding for training.

3.3.6 As the process of implementing AfC draws to an end, the focus will shift to realising the benefits. The experience in the NHS demonstrates some of the pitfalls and these are highlighted in the report of the Westminster Public Accounts Committee[11] published in June 2009 (although these relate to the Department of Health and the National Health Service in Great Britain, there are lessons for DHSSPS and the HSC in Northern Ireland). The Westminster Report highlighted that:

- the Department of Health and NHS trusts did not establish ways of measuring the effects of Agenda for Change and there was no active benefits realisation plan;
- the NHS pay bill for staff employed on Agenda for Change terms and conditions of service had risen by 5.2 per cent a year on average since 2004–05 while productivity fell by 2.5 per cent a year on average between 2001 and 2005; and
- by autumn 2008 (nearly two years after trusts had completed transferring staff to Agenda for Change terms and conditions and pay rates) only 54 per cent of staff had participated in a knowledge and skills review.

3.3.7 The Department will need to ensure that it can demonstrate clearly the impact of AfC in its mission to improve the health and social well-being of the people of Northern Ireland. As the process draws towards its conclusion, it is perhaps an appropriate point to undertake an initial benefits assessment. The Department has plans to undertake a review of benefits realisation. For our part, we will consider this subject further in the coming year.

11. HC 310, Westminster Public Accounts Committee 'NHS Pay Modernisation in England: Agenda for Change'

Part Four:
Project Management – ICT Projects

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Project Management – ICT Projects

4.1.1 Project management is defined by the Office of Government Commerce (OGC) as *a unique set of co-ordinated activities, with definite starting and finishing points, undertaken by an individual or team to meet specific objectives within defined time, cost and performance parameters*. There is no established approach to guarantee that a project is successful, but there are several proven techniques available to help plan and manage projects. The principles of project management are well-embedded in the public sector.

4.1.2 Nevertheless, the history of information communication technology (ICT) projects in the UK public sector provides a number of examples of failed project management. The National Audit Office recently reported on the National Offender Management Service's attempt to build a single offender management IT system for the prison and probation services. It found the project had not delivered value for money, hampered by poor management leading to a three-year delay, a doubling in project costs and reductions in scope and benefits.[12] Other reports, such as that on the National Programme for IT in the NHS[13], have also raised significant project management issues.

4.1.3 Our audit in 2009 identified a number of ICT projects in the HSC which, for various reasons, did not deliver the benefits expected. These included:

- the Person-Centred Community Information System (PCIS);
- the Electronic Prescribing and Eligibility System (EPES); and
- the GMS probity (IT services) project.

4.1.4 There was also a backlog in post project evaluations (PPE) of completed projects within the HSC which has now been addressed by the Department. We discuss each of these issues below.

Person-Centred Community Information System

4.2.1 PCIS was conceived as a means to address the information needs of the community sector of the HSC by way of a single ICT solution to be used by 10 community trusts to replace all of their ICT systems across social care, mental health, children's and community services. PCIS commenced on approval of a project initiation document in August 2000. An invitation to tender for the provision of ICT services was placed by the Department in January 2001. From 23 expressions of interest, six tenders were received. Due to the scale and complexity of the requirement and the number of stakeholders, short listing took six months. Contract negotiations with three potential suppliers began in October 2002.

4.2.2 The Department told us that the procurement process had to cope with substantial change, with the result that subsequent activities were protracted. With OGC guidance, the original objective was to establish a framework contract from which trusts could purchase elements of the overall solution as

12. The National Offender Management Information System, National Audit Office, March 2009
13. The National Programme for IT in the NHS, National Audit Office, May 2008

and when funding became available. However, in April 2004 central funding was secured and, based on OGC advice, the objective of the procurement became the establishment of a single contract for the delivery of the PCIS solution. Contracts were then negotiated and well advanced when, in early 2005, in common with other major public sector contracts, OGC required PCIS to change to its new National Programme for IT (NPfIT) contract terms and conditions rather than using the model recommended previously. As a result, the project lost a further 7 months in re-writing contract terms and conditions to the NPfIT format.

4.2.3 One of the candidates withdrew in June 2004, due to a change in their business direction, but by November 2005, draft contracts with the remaining bidders were in place. The non-financial evaluation concluded in January 2006. During the Best and Final Offer (BAFO) evaluation, which commenced in January 2006, concerns were raised over the commercial viability of one of the bidders. Following a period of intense "due diligence" this bidder withdrew in October 2006. The evaluation process was completed with the formal conclusion that the remaining bidder and its solution were acceptable. This bidder was awarded "preferred bidder" status in November 2006. A final business case, containing the preferred bidder's BAFO costs and contractual timescales, was approved in July 2007. However, during the process leading to the signing of the contract, serious concerns emerged over the preferred bidder and its nominated sub-contractor. The preferred bidder sought to lengthen already agreed delivery timescales and increase already agreed costs, and made requests to change previously agreed terms and conditions. Once it transpired that the preferred (and only remaining) bidder was unable to meet its best and final offer commitments, the procurement was terminated in October 2007.

4.2.4 By this time, the overall project had spent more than £9.3m. £7.7m of this was spent on service modernisation, £4.3m of which was provided by the Executive Programme Funds (EPF) Modernisation Fund. The EPF post project evaluation report indicated that the EPF funding was spent productively on service improvement. The independent "Review of the PCIS Procurement Project" in January 2008 also concluded that PCIS had made a considerable contribution to service modernisation and that solid foundations had been laid for any successor project. Nevertheless, it also recognised that while the failure of the procurement was in the end due to the inability of the bidder to meet its best and final offer commitments, there were wide ranging lessons to be learned and that important project management disciplines were lacking:

- the need for 'the right people, with the right skills at the right time' was not met (the report concluded that PCIS was under resourced for an exercise of this scale and complexity);

- a distinct budget for project management costs was not established and monitored;

Part Four:
Project Management – ICT Projects

- there was no evidence of a formal procurement strategy being established before the original tender in January 2001, although the project formally agreed and documented the procurement route to be followed and the Office of Government Commerce was involved throughout, providing ongoing professional procurement advice and guidance; and

- time taken to complete key procurement activities was excessive. The Department told us that this was largely due to the scale and complexity of the requirement and the number of stakeholders as well as the changes in circumstance.

4.2.5 The cost of the project was £9.3m. Of this, £7.7m was spent on service modernisation by the trusts, which wrote off £0.8m in 2007-08 as a result of the termination of the procurement. Of the remaining £1.6m, the Department was able to use £0.33m of PCIS assets on other projects and wrote off other expenditure worth £0.34m in 2007-08. A series of re-usable products were also developed and lessons learnt which the Department believes will bring significant benefit to future projects in this area.

Electronic Prescribing and Eligibility System

4.3.1 The EPES project was initiated by the Department to explore the feasibility and potential benefits of a system to apply ICT solutions around the prescription process and to support fraud control within the health and social care sector. A business case was approved in May 2006 and, following a competitive procurement process, the system was implemented and operational on 1 May 2008.

4.3.2 The original primary objective of EPES was to identify and reduce prescription fraud committed through false patient exemption claims. Secondary objectives were around improving the laborious business processes within the Central Services Agency. To this end, the Department budgeted for £16.8m in resources over the period 2006-07 to 2013-14 (£4.3m in capital, £12.5m in revenue funding). The anticipated financial benefits, in reduced fraud and improved business processes, were estimated to be more than £60m[14].

4.3.3 In practice, these are unlikely to be realised. The Ministerial announcement in September 2008 of the introduction of free prescriptions in Northern Ireland from 1 April 2010 in effect negated EPES' primary purpose and its anticipated financial benefits.

4.3.4 This is not to argue that the system has no value. Outdated business systems and processes in the Family Practitioners Service have been replaced and the Counter Fraud Unit in the new Business Services Organisation (BSO) has access to an enhanced range of data to facilitate its work.

4.3.5 The Department told us that, in the absence of prescription charges, patient fraud with regard to prescription payments ceases to be an issue. So the business case for EPES was revisited and it was concluded that

14. Post Project Evaluation, Directorate of Information Services, 2009

the system - which can provide data on the patient's identity, age, social security status, identity of the prescribing GP or other health professional, prescription items prescribed and dispensed (as well as exemption claim status and whether any evidence of eligibility was produced) - would continue to offer an invaluable resource of information on prescribing and dispensing probity, and assist in the identification of other fraudulent activity in the prescription service. This would, of itself, justify its introduction (for example, to examine prescribing and dispensing trends, to provide a link between primary and secondary care drugs data at individual patient level, or for probity purposes) even if prescription fraud were no longer an issue.

4.3.6 Moreover, it told us that EPES has already:

- given the HSC sector one of the first, fully patient-centred prescribing databases in Europe, that will continue to have a positive impact in the assessment of patient safety, the probity of the prescribing cycle, prescribing costs, and treatment outcomes;

- computerised the BSO payments processes for the cost of drugs dispensed and dispensing fees, which have previously been paper-driven. This is a major operation dealing with some 1.4 million prescription items a month, and rising, currently at a rate of some 5 per cent a year (as in other parts of the UK);

- allowed electronic on-line access to scanned images of the prescriptions, saving time, costs and effort in manual prescription retrieval from off-site storage and internal office handling;

- allowed the probity in medicine prescribing, ophthalmic provision and dental services, to be cross referenced against individual practitioners, patients and their associated demographics;

- reduced the dangers and errors that arise from unclear or illegible prescriptions, thereby improving patient safety; and

- improved the efficiency and accuracy of reimbursement to pharmacists.

4.3.7 The full benefits of EPES to the business process will not be realised until the Department can reach agreement with the Pharmaceutical Contractor Committee, who represent the community pharmacists in Northern Ireland, on implementing the second phase of the project to allow the electronic transfer of monthly claims and payment files between community pharmacies and the BSO (known as eClaims). At this time, there is no sign of agreement being reached. As a result, and recognising these wider issues, the EPES project has re-evaluated and re-assessed the benefits and projected spend for the completion of eClaims. A revised and updated business case for EPES (Phase 2 eClaims), which reduces the anticipated spend to £5.7m, is currently under

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Project Management – ICT Projects

review by the Department to assess if the introduction of eClaims remains a feasible and value for money option.

GMS probity project

4.4.1 A new General Medical Services (GMS) contract was implemented across the UK on 1 April 2004. Updated guidance on post payment verification by the boards was issued by the Department in July 2006 to take account of the new contract. In response, the boards agreed that an ICT based approach should be taken to routine post payment verification. The Eastern Board, on behalf of the four boards, proceeded to tender through the Regional Supplies Service for an IT consultant to produce a suite of queries for use in GMS probity checking in 2006.

4.4.2 A contract valued at £58,000 was awarded in February 2007 to the only tenderer. However, progress was slow, due to problems with the software used to write the enquiries and to the withdrawal of GPs' cooperation in the pilot to test the new suite of queries. Consequently, the contractor was able to deliver only a limited proportion of the objectives built into the contract as triggers for payment.

4.4.3 In September 2007, the contractor issued a compensation claim for £45,000 in addition to the value of the contract. The Eastern Board, acting on legal advice, terminated the contract from 4 April 2008 while continuing negotiations with the contractor. These proved unsuccessful and in June 2008 a writ was served on all the boards for the fair value of the contract, the compensation claim and damages. The claim was settled out of court for £50,000 plus costs and each of the boards reported its share of the losses in the 2008-09 accounts.

Post project evaluations

4.5.1 It is a core principle, set out in HM Treasury's Green Book (promulgated in Northern Ireland by the Department of Finance and Personnel), that when a policy, programme or project has been completed, it should be evaluated to examine the outturn against what was expected and to ensure that lessons learned are fed back into the decision-making process. DFP's Practical Guide to the Green Book (currently being revised) and other documentation provides further guidance on when, and how, these evaluations should be carried out.

4.5.2 At the time of this review in 2009, forty one such policies, programmes and projects – covering capital, revenue and ICT proposals and going back to June 2007 - in the HSC sector had yet to be subject to post project evaluation (PPE).[15] The Department told us that it has now made significant improvements in the timeliness of its PPE preparation and monitoring. All PPEs have now been submitted to DFP.

4.5.3 The Assembly's Finance and Personnel Committee has taken evidence on post project evaluation which pointed to a wide range of initiatives in the public sector that

15. DFP letter to the clerk of the Finance and Personnel Committee, 5 December 2008

under current rules should be subject to PPE, but which are not actually 'projects', for example business cases for the use of consultants. DFP considers that it would be more beneficial if departments focused on major projects and the preparation of lessons learned reports and other evaluations rather than requiring a PPE for every business case which is prepared. DFP is currently revising its economic appraisal guidance in this context and may not request copies of every PPE in the future. We would then expect the Department to re-focus its attention on learning the lessons from the significant projects undertaken in the HSC sector. Under current guidance, the Department must continue to complete PPEs for all projects. We will consider this subject further in the coming year.

Learning the lessons

4.6.1 We consider that these ICT projects hold important lessons for the HSC sector. Projects fail typically when they are not well-managed; inadequately planned; insufficiently resourced; poorly led; or exposed to risks that have not been mitigated. The adoption and rigorous implementation of a project management methodology, for example PRINCE2, would have done much to identify and mitigate the unanticipated risks of software incompatibility and GPs' lack of cooperation which held back the GMS probity project. The PCIS independent review concluded that the PCIS "project team were under-resourced for an exercise of this scale and complexity." A more robust implementation of PRINCE2 would have highlighted the weaknesses in resource planning and resource management which damaged PCIS. Without these disciplines, these projects were exposed to a high risk of failure.

4.6.2 The EPES project appears fundamentally different. It has been successful. The HSC sector now has a single, patient-centred, electronic history of prescribing and dispensing in primary care; and the ability to electronically call up and view each of the 16.8 million prescription forms returned annually to the BSO. This replaces the paper based manual handling systems that the Central Services Agency was previously dependent on. EPES' primary purpose is now a very different one to that which was approved in the 2006 business case. We will follow its progress with interest in the coming year.

Part Five:
Third party funds

Part Five:
Third party funds

5.1.1 Stewardship, as with all public sector organisations, is an essential part of the HSC sector's responsibilities. HSC bodies are required to account for the public funds that they administer in their annual financial statements. Some HSC bodies also hold funds on behalf of third parties, namely charitable funds and patients' and residents' monies. This section discusses the administration of these funds.

Charitable funds

5.2.1 HSC trusts operate Charitable Trust Funds (CTFs) side by side with their public funds. CTFs are much smaller in value than public funds: trusts held balances of £41m at 31 March 2009 (£47m at 31 March 2008). The Northern Ireland Blood Transfusion Service also held a very small charitable fund. Charitable funds arise generally from patients and third parties making donations to hospitals or other bodies in recognition of treatment received or as a contribution towards research. HSC bodies account for these funds each year through a separate set of financial statements which are audited by the Northern Ireland Audit Office. Trustees are appointed for each body, usually board members, and Charitable Funds Advisory Committees are delegated powers to act in the management and governance of trust funds.

5.2.2 Where there is a legal restriction on the purposes to which a fund may be put, that is, where funds have been donated for specific purposes, the funds are classified as restricted funds. Endowment funds are those where the capital is held to generate income for charitable purposes and the capital cannot be spent. All other funds are classified as unrestricted funds. Thus, while HSC bodies have the responsibility of stewardship over all donated funds, they do not have unfettered power to dispose of all these funds in any way they choose.

5.2.3 The governance of such funds is an essential aspect of proper financial stewardship. In recent years, we have reported some concerns:

- at South Eastern Trust, the Trust Fund Committee did not meet during the year ended 31 March 2008. However, the Department told us that the Committee had previously approved the level of funds to be expended during 2008-09. The investment management of the funds is undertaken by the NI Charitable Funds Investment Committee in a pooled arrangement for all HSC bodies. This fund had a balance in excess of £6m. While the Trust Fund Committee did meet during 2008-09, it is essential for the Committee to continue to meet regularly to facilitate effective management of the funds;

- a lack of established procedures at the legacy trusts resulted in inconsistent standards of documentation at the Belfast Trust during 2007-08; and

- record keeping at the Southern Trust was not undertaken in a timely manner in 2007-08. Income and expenditure records were not updated on a regular basis on the accounting system and bank reconciliations were not

completed promptly. The use of Gift Aid forms was not promoted or maximised to increase the value of donations. Nevertheless, financial records were complete by the year end and the trust fund accounts received an unqualified audit opinion.

5.2.4 We have noted a tendency for balances in charitable funds within the HSC to build over the longer term, as annual expenditure fails to keep pace with income. The Department drew attention to trustees' strategic approach to balance expenditure with income each year. For a number of years, the capital base of these funds has benefitted significantly from market growth, but the recent economic downturn has reversed this. Reliance on income, which has taken a downward trend, has had to be backed up by interest income generated from this accumulated capital base, particularly to meet recurrent expenditure.

5.2.5 We believe that this strategic approach is a valid one, and it is not, of course, desirable to spend funds merely to reduce an accumulating balance. However, health bodies risk failing in their duty of stewardship if they do not disperse the funds to achieve the wishes and objectives of the individual patients, businesses and others who make these gifts and bequests. Also, failure to use charitable funds in circumstances where their use is justified potentially creates further pressure on public funds. Figure 5 illustrates trusts' use of charitable funds in 2008-09 and shows that the accumulated balance of £46.9m of funds held at 31 March 2008 had reduced to £41.3m by 31 March 2009, yet income at £5.9m was greater than expenditure at £4.3m during the year.

5.2.6 What may be interpreted as a conservative approach to spending has had some unforeseen consequences. Whilst it is

Figure 5: CTFs income & expenditure 2008-09

HSC Trust	Balance at 31 March 2008 £000s	Income £000s	Expenditure £000s	Balance at 31 March 2009[16] £000s
Belfast	29,805	2,845	2,054	25,589
Northern	4,702	945	935	4,367
NI Ambulance Service	16	3	3	15
South Eastern	6,398	738	288	5,754
Southern	2,811	831	520	2,711
Western	3,139	570	477	2,836
Total	**46,871**	**5,932**	**4,277**	**41,272**

Source: Trusts' CTF accounts 2008-09

16. Includes realized losses on the value of investments during 2008-09 – see paragraph 5.2.6.

Part Five:
Third party funds

recognised that the investment of funds in the past has led to the enhancement of balances because of favourable market conditions, the decline in the global stock market during 2008-09 has had a significant impact on the value of charitable funds' investments over that period. The value of investments in the Common Investment Fund fell by £6.2m (18 per cent) in the twelve months to 31 March 2009. This is value which, unless market values rise again in the long term, may be lost to the vagaries of the market in the aftermath of the credit crunch. Trustees of these funds must question whether these losses could have been alleviated if fund managers in the trusts had taken a more active approach to managing their charitable fund balances. This may have included increasing expenditure from funds when it was evident that market conditions were likely to take a downturn. We urge the HSC sector to make greater efforts to realise the value in charitable funds for the benefit of patients, staff and the public.

5.2.7 Substantial cash balances continued to be held with Irish banks during the latter part of 2008, despite the increasing evidence of their financial instability before the Irish government stepped in to guarantee deposits. The Department told us that no losses were incurred during this period. Neither were there investments affected by the widely reported failure of the Icelandic banking system. However, in our view, this demonstrated a very passive attitude to safeguarding these funds. The Department withdrew its list of approved financial institutions for investment, which included a number of banks at risk, in February 2009 and health bodies subsequently took steps to transfer funds away from the banks which apparently present the highest risk.

Patients' and residents' monies

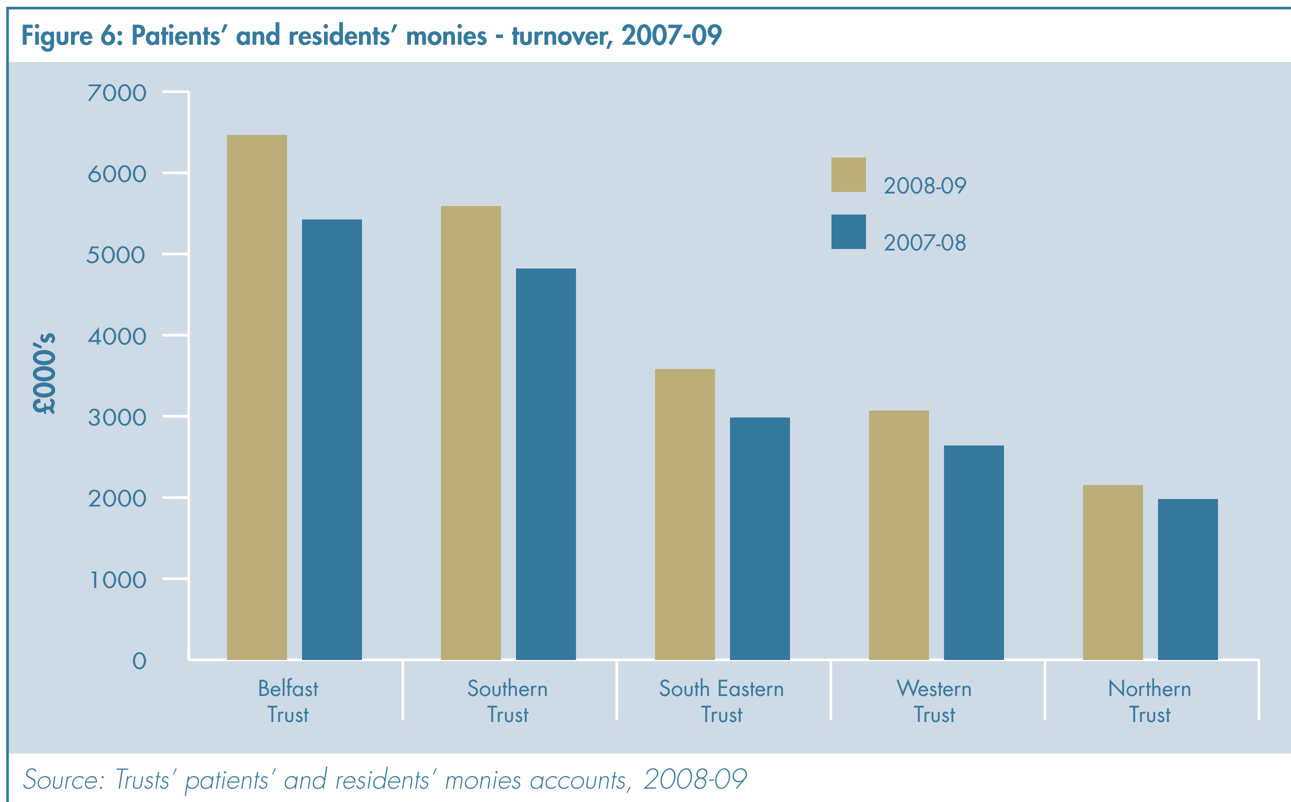
5.3.1 Trusts' patients' and residents' monies accounts turned over (that is, received or paid out) almost £18m in 2007-08. This increased to nearly £21m in 2008-09 (Figure 6). Typically, these accounts hold the funds of long-stay patients (often accrued from social security benefits), although an element derives from the cash and property held by patients undergoing short term hospital care. These monies are accounted for separately from public funds and are subject to audit.

5.3.2 The audits in 2007-08 identified a number of issues, including examples of inadequate record keeping:

- failure to record transfers of cash between hospital wards and the cash office;
- failure to lodge monies received in the cash office to the bank. As a consequence, money was not recorded in the accounts; and
- failure to receipt the return of cash to the patient.

In each case, trusts' management committed to addressing the issues identified. With the exception of the Belfast Trust, the 2007-08 patients' and

Figure 6: Patients' and residents' monies - turnover, 2007-09



Source: Trusts' patients' and residents' monies accounts, 2008-09

residents' monies accounts received unqualified audit certificates.

5.3.3 Weakness in the controls and procedures at the Belfast Trust led to audit qualifications of the accounts in 2007-08 and 2008-09. Significant issues also arose at the Western Trust in 2007-08 and the Trust introduced procedures to strengthen controls. While the audits at HSC trusts in 2008-09 demonstrated progress, and other than Belfast received unqualified audit certificates, we continued to report the failure to receipt the return of cash to the patient. We also noted a number of cases of theft from patients and residents. In December 2009 the Department issued a reminder to organisations of the mandatory controls that should be in place in respect of the handling of residents' monies in statutory homes and seeking assurance that trusts' residents' interests are protected when placed in independent sector care homes.

5.3.4 Of further concern, during 2007-08, the Mental Health Commission failed to discharge its statutory responsibility to undertake an evaluation of trusts' arrangements to safeguard patients' and residents' monies. This was a major failing. The importance of proper regulation of these funds cannot be over-emphasised. Patients' and residents' monies are not public funds: rather, they are the personal property of some of the most vulnerable members of society, care of which is

entrusted to the HSC sector. The Regulation and Quality Improvement Authority (RQIA) assumed responsibility for the functions of the Mental Health Commission on 1 April 2009 and was required to meet its statutory responsibilities in respect of patients' and residents' monies. A programme of work was established, consisting of the following actions:

- requesting assurances from trusts concerning records and procedures for monitoring patients' and residents' monies;
- assessing and evaluating the responses from trusts;
- seeking further information as necessary where gaps in information and assurances have been identified; and
- on the basis of the information obtained, drawing up and agreeing with trusts a monitoring format and timetable on a continuing basis.

5.3.5 We understand that the RQIA has completed actions one and two, and the third is in progress. We will continue to monitor this area of HSC activity.

Part Six:
Governance

Part Six: Governance

6.1.1 Governance is the system of accountability, to service users, stakeholders and the wider community, within which organisations lead and direct their activities to achieve their objectives. In our last General Report we commented upon a number of positive developments in the governance of the HSC sector and highlighted some issues for further attention. In this report we consider some of the latest developments in the governance of the health and social care sector:

- the governance review of the NI Ambulance Service Trust;
- quality inspection of the NI Blood Transfusion Service;
- conflicts of interest;
- remuneration of senior employees; and
- the assurance framework.

Governance review of the NI Ambulance Service Trust

6.2.1 In 2008, we reviewed the governance arrangements in the Trust as a standalone exercise to test the implementation of best practice within a public sector environment, including compliance with the Department's guidance. Specifically, we considered:

- governance structures;
- systems;
- accountability arrangements;
- clinical and social care governance; and
- risk management.

6.2.2 Overall, corporate governance arrangements at the Trust were strong and appropriate to the nature and size of the organisation. We noted a number of features of good practice, including:

- the Board's clear understanding of the role of the Trust as a public body, and the development and communication of its function, vision, mission and core values to stakeholders;
- the cross-fertilisation of skills between the Audit, Clinical Governance and Risk Management Committees, which sees the Chair of the first two committees also sitting on the third; and
- a strong focus on risk management within the Board and the Clinical Governance Committee, as well as the Risk Management Committee.

6.2.3 We identified some significant issues:

- a need for effective succession planning at Board level, for instance in managing the transition between the Chairman and his successor;
- neither of the non-executives on the Clinical Governance Committee had a clinical background which may have limited their ability to act as an effective challenge. However, following a review to match skills and roles, the

Clinical Governance Committee is now chaired by a recently appointed non-executive director with a clinical professional background;

- a need for formal performance assessments of the Board and its sub-committees; and
- a need for improved controls to prevent and detect errors in and manipulation of performance data.

6.2.4 We made a number of recommendations for action by the Trust and the Department in our report issued in July 2008. The Trust has embarked on a major restructuring of its governance arrangements and is using the results of our review to inform its thinking. Action to implement recommendations made is continuing. We, in turn, will continue to monitor the Trust's implementation of its plans.

Quality inspection of the NI Blood Transfusion Service

6.3.1 During March and April 2008, the NI Blood Transfusion Service (NIBTS) was subject to a routine inspection by the Medicines and Healthcare products Regulatory Agency (MHRA), under the terms of the Blood Safety and Quality Regulations 2005. This revealed a number of serious control weaknesses with respect to NIBTS's Quality Management System. MHRA concluded that significant failings in elements of good practice meant that the operation was not sufficiently robust and had the potential to result in patient harm, although there was no evidence that any patient had come to harm. Amongst the findings were:

- weaknesses in managing incidents, such that quality failures were not investigated and remedial action taken promptly in response;
- inadequate document control, for example, obsolete records of cleaning of equipment;
- poor equipment maintenance and calibration; and
- inadequate control of laboratory operations.

6.3.2 A re-inspection was planned for November 2008. The potential implications of repeated failure to meet regulatory requirements would have included the withdrawal of the Blood Establishment Authorisation licence for the Blood Transfusion Service. In July 2008,NIBTS submitted a business case for £85,500 to the Department for approval to engage consultants for the period 8 June to 30 November 2008, to help implement a series of corrective measures. This was revised in liaison with the Department and a final business case for this work, valued at £112,000, was submitted to DFP in mid November 2008. A second business case for £31,600 was submitted to DFP on 3 December 2008.

6.3.3 In February 2009, DFP confirmed approval of £13,600 of the second business case and advised the Department

Part Six: Governance

that retrospective approval for project expenditure totalling £130,000 (that is £112,000 from the first business case plus £18,000 from the second) would not be granted, as:

- a suitable business case had not been completed and approved before engaging the consultants in June 2008; and
- the Minister for Health had not approved the project before consultants were engaged.

6.3.4 As a consequence, this expenditure was deemed to be irregular and we qualified the regularity opinion on the Blood Transfusion Service's 2008-09 accounts. There is no question that the expenditure was necessary and urgent, but the failure of NIBTS and the Department to submit the business case in time contravened DFP regulations.

6.3.5 Of more concern is why the systems and controls within NIBTS deteriorated to the extent identified by MHRA. NIBTS told us that it was more the case that systems and controls were not sufficiently enhanced to meet the requirements of the Blood Safety and Quality Regulations 2005. A repeat inspection was undertaken by MHRA in November 2008 for which there was a satisfactory outcome. Action plans were developed to address recommendations made as a result of the November 2008 inspection. A further inspection undertaken in July 2009 resulted in a satisfactory outcome and MHRA indicated it would return NIBTS to a normal bi-annual inspection cycle.

6.3.6 Given the risks involved it will be important that the Department, as the sponsoring body, satisfies itself that the situation which led to the adverse MHRA report in April 2008 has been properly addressed and that there are no prospects of it recurring.

Conflicts of interest

6.4.1 Avoiding conflicts of interest is a vital issue for the public sector. The PAC has reported critically on a number of cases where conflicts of interest have damaged the business and the reputation of the organisation concerned. The PAC reports on the Hospitality Association of Northern Ireland[17] and the Northern Ireland Tourist Board[18] are noteworthy recent examples.

6.4.2 Public sector bodies have a range of controls and procedures to assist them in avoiding actual and perceived conflicts of interest. Registers of interest record the outside interests of senior managers which could be perceived to have an impact on their conduct of public business. Registers of gifts and hospitality record the offering, refusal or acceptance of gratuities by public servants which could be perceived to influence their decision making. FRS8[19] requires the disclosure in the annual accounts of the details of any significant related party transactions, i.e. financial transactions between bodies that could be perceived to have been influenced by the existence of an undisclosed relationship between those bodies – for example, where a senior manager in one organisation is also a board member of another organisation.

17. 36/07/08R Public Accounts Committee 'Report on Hospitality Association of Northern Ireland: A Case Study in financial management and the public appointments process'
18. 35/07/08R Public Accounts Committee 'Report on Northern Ireland Tourist Board – Contract to Manage the Trading Activities of Rural Cottage Holidays Limited'
19. Financial Reporting Standard 8, Related Party Transactions

6.4.3 These arrangements are established in the HSC sector, but the practice of disclosing related party transactions is not yet well-developed. Isolated examples of good practice exist - the Western Trust can be commended for a comprehensive disclosure in its 2008-09 accounts – but overall, the quality of FRS8 disclosures is poor. Few health bodies disclosed relationships, even where they were known to exist. Where disclosures were made they were incomplete, lacking financial detail.

6.4.4 This is not a desirable state of affairs. The PAC has made its intentions clear: *The Committee regards full disclosure of related party transactions as a valuable safety net for ensuring that potential conflict of interest issues are addressed in annual accounts.*[20] We consider that all HSC bodies should be disclosing significant related party transactions where they exist, and we will focus on this issue in 2009-10.

Remuneration of senior employees

6.5.1 Since 2003-04 there has been an expectation that senior employees of HSC bodies should disclose their salary and pension details in the accounts each year. In last year's General Report we noted the gradual adoption of this practice in the last few years, culminating in comprehensive disclosures in the 2007-08 accounts by most bodies. Only in three cases in the Northern Board did current senior managers withhold permission for these details to be published after proper assessment and approval by the Board. Another two former executives of legacy trusts, whose severance payments should properly have been reported in the accounts of the new merged trusts, also withheld consent.

6.5.2 This position was sustained in 2008-09. The same three individuals in the Northern Board withheld permission to publish salary and pension details, and once again these cases were assessed and supported by the Board. All others in the HSC sector made this disclosure. While it is disappointing that full disclosure was not made across the health and social care sector, we are encouraged by the levels of disclosure that were achieved. It will be important to sustain this in 2009-10, when a cadre of senior managers - some of whom may be unfamiliar with these requirements - in the new health bodies created under RPA will be called upon to make these disclosures. We understand that disclosure is now a contractual requirement for senior employees in the HSC sector. We will continue to review compliance.

The assurance framework

6.6.1 Good governance depends on having clear strategic objectives; sound business practices; a clear understanding of the risks and internal controls associated with the organisation's operations; and effective monitoring arrangements. The Department has taken a number of important steps to promote good governance in HSC organisations in the last few years – prescribing codes of accountability and conduct, introducing mandatory risk management arrangements and requiring

20. 36/07/08R Public Accounts Committee 'Report on Hospitality Association of Northern Ireland: A Case Study in financial management and the public appointments process'

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the Accounting Officer to disclose the effectiveness of the system of internal control in an annual statement. From 2009-10 the Accounting Officer is also required to issue a mid-year assurance statement attesting to the continuing robustness of the organisation's system of internal control.

6.6.2 Perhaps the most important recent development is the introduction of a mandatory assurance framework for HSC bodies. Based upon guidance issued in 2006 and updated to reflect the experience gained since then, the assurance framework is designed to provide a clear, concise structure for reporting key information to the board of the HSC body about the organisation's governance. It identifies which of the organisation's objectives are at risk because of inadequacies in control, or where the organisation has insufficient assurance about the operation of controls. It should also provide structured assurance about how risks are managed effectively to deliver agreed objectives. The Department believes that the updated guidance is critically relevant to the maintenance of control as the HSC sector continues to undergo major change.

6.6.3 The guidance is extensive and in principle, provides a sound basis for maintaining effective governance in the HSC sector. However, HSC bodies should recognise that good governance flows not just from the structures and processes established, but also from the rigour with which they are operated. The true test of effectiveness lies in the difference that these arrangements make to the day to day business of delivering health and social care in Northern Ireland.

6.6.4 There are some important lessons to be learned from the experience in the NHS, where a mandatory assurance framework has been established for some time. Certainly, the existence of an assurance framework did not serve to prevent some high profile failures in patient care, such as those at Maidstone and Tunbridge Wells NHS Trust and Mid Staffordshire NHS Foundation Trust. The Audit Commission, in reviewing the process of how trust boards gain their assurance, has highlighted some of the limitations of the approach[21]:

- few NHS trusts had a manageable number of clear strategic objectives that would enable risks to be readily identified and managed;
- some trusts found it difficult to embed risk management in the day-to-day running of the organisation and had not linked it effectively to performance management and performance information;
- controls and assurances were often poorly defined, making it difficult to see how boards could be clear that the controls were working effectively and that assurances were sound. Risks and controls were not always aligned to strategic objectives; and
- in the worst cases, the assurance framework had become a paper chase rather than a critical examination of the effectiveness of the trust's internal

21. Taking it on trust, Audit Commission, April 2009

controls and risk management arrangements.

6.6.5 In light of the Audit Commission's review, HSC organisations attended a master class given by the consultant who carried out the review, on developing and maintaining Assurance Frameworks. This enabled participating organisations to learn from the experiences of the NHS in developing, implementing and maintaining Assurance Frameworks. It is clear that these are lessons which the HSC sector cannot afford to ignore. The importance of a positive organisational culture – one which promotes and endorses good governance, from the boardroom to the shop floor – is now well established as an essential principle. We will undoubtedly return to this matter in future reports.

NIAO Reports 2009-2010

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