Northern Ireland
Assembly

COMMITTEE FOR
HEALTH, SOCIAL SERVICES AND
PUBLIC SAFETY

OFFICIAL REPORT
(Hansard)

Departmental Response to the 'General Report on the Health and Social Care Sector in Northern Ireland – 2008'

11 March 2010

NORTHERN IRELAND ASSEMBLY

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Departmental Response to the 'General Report on the Health and Social Care Sector in Northern Ireland – 2008'

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Members present for all or part of the proceedings:
Mr Alex Easton (Acting Chairperson)
Mr Thomas Buchanan
Mr Sam Gardiner
Mrs Dolores Kelly
Mr Conall McDevitt
Mrs Claire McGill

Witnesses:
Mr Sean Donaghy)
Dr Jim Livingstone) Department of Health, Social Services and Public Safety
Mr Dean Sullivan)

The Acting Chairperson (Mr Easton):

I welcome the witnesses from the Department of Health, Social Services and Public Safety (DHSSPS). We have with us Mr Sean Donaghy, the Department's undersecretary of resources and performance management; Mr Dean Sullivan, the director of planning; and Dr Jim Livingstone, the director of safety, quality and standards. I invite the witnesses to take 10 minutes for their presentation, after which members' questions will be invited, before I bring the session to a close in about an hour's time.

Mr Sean Donaghy (Department of Health, Social Services and Public Safety):

Our most recent presentation to the Committee for Health, Social Services and Public Safety probably took longer than the allocated 10 minutes. We hope to recover some of that time today. I alone will deliver our opening remarks.

The Acting Chairperson:

So it will be only five minutes. *[Laughter.]*

Mr Donaghy:

I will confine my remarks to five or six minutes to provide the maximum opportunity for questions.

It is important to note that the 'General Report on the Health and Social Care Sector in Northern Ireland – 2008' is for 2007-08, and it reflects the fact that the process has, thus far, been novel, with the Public Accounts Committee (PAC) having passed the report to this Committee as part of a pilot project. The report has not previously been scrutinised in any depth. Nonetheless, we welcome that process and the opportunity that it provides to shine a light on some matters that are covered by the report. Given that it refers to 2007-08, we may add information about developments since then to help the discussion.

Section 4 of the report covers governance, including clinical governance. It is difficult to overstate the importance of those two areas, which have been at the heart of the Department's development agenda over past years. I will return to governance matters later.

The report starts by clearly setting out the roles of the statements of internal control by trusts and the importance of the drive towards improved openness and transparency in those statements. We welcome that because we have pursued that aim. We also welcome some of the acknowledgements of progress. As the report notes, improvement is always possible. Some further developments have strengthened the use of statements of internal control, including, for example, since the time of the report, making those statements half-yearly rather than annual. Thus, two opportunities are provided to consider whether matters require attention and how to address them from the Department's perspective, because arm's length bodies report to it.

I want to talk briefly about the Department's approach to clinical governance. Nothing could

be more central to the drive for improved quality in the provision of health and social care services. The Committee may be familiar with 'Best Practice: Best Care', which the Department published in 2001. That consultation paper set the guidelines and the direction for the future development of clinical governance. It outlines three key building blocks, and it is worth reprising those. First is the clarification of the responsibility of the Department as the body that needs to set standards. A range of measures was put in place to support that standard setting, including the establishment of links with organisations such as the National Institute for Health and Clinical Excellence (NICE), the National Patient Safety Association and the Social Care Institute for Excellence (SCIE), which help us to formulate, with due reflection, the quality of those standards.

Secondly, in 2002 and 2003, there was the introduction of a duty of quality across health and social care bodies and a personal responsibility for a duty of quality from chief executives. That is a central plank to support the development of clinical governance in trusts and other arm's length bodies.

Thirdly, the Regulation and Quality Improvement Authority (RQIA) was established in 2005 to provide an independent oversight of arm's length bodies, including, importantly, trusts. It examines performance against quality standards and reports independently to the Department and in the public arena.

Those are the three key elements: clarity on standards; clarity on who is responsible for ensuring that quality standards are met; and clarity that there is an independent voice to examine those standards and to report on that to the Department and to the public. There is a range of other supporting activities, and I am sure that our discussion will draw some of those out.

The 2008 report comments on views that are promulgated by the RQIA. The Department charges the RQIA with the role of independent scrutiny, oversight and public reporting. We welcome the reports that the RQIA, as an arm's length body of the Department, makes to us to highlight the areas for improvement. The report, for example, picks up on infection control. The RQIA has played a central role in ensuring that the scale of the challenge is understood and reported openly and that there is a clear agenda for future improvement.

A specific example of the RQIA's work is its investigation into the outbreak of clostridium

difficile in the Northern Health and Social Care Trust area. Lessons were learned from that investigation, and those were promulgated across the service. Clostridium difficile rates have reduced and are running at some 50% of the rate that prevailed in 2006-07.

We welcome the challenges that the report sets out for improvement. From our perspective, the improvement journey can never come to an end. There is always room to do better, and we will continue to strive to raise standards.

We take seriously the concerns that the report raises on procurement. Improvement activity is led by the centre of procurement expertise (COPE), which is the procurement and logistics centre. For example, the use of procurement process override forms — CF61 forms as they are referred to in the report — has dropped dramatically since 2008. It is clear that some 80% of those overrides are based on the need to procure a product that is consistent with other clinical supplies and equipment rather than simply introducing an unfamiliar product.

Legal services have been reviewed in some detail by the Public Accounts Committee, and I do not propose to comment on that issue now. Members may wish to raise questions on that. Further progress has been made on reducing prescription fraud. I do not intend to talk about any of the other areas in detail, but members may also wish to raise those.

The Acting Chairperson:

I shall start with a few questions. It will be nothing too heavy.

Paragraph 5.2.1 states that consultants can insist, in their clinical judgement, that a particular supplier, brand or model of equipment must be used. When consultants have that amount of power to dictate what company is used, can the establishment of the systems and procedures lead to effective procurement?

Mr Donaghy:

One measure that we have taken is to bear down on the number of occasions when exceptions are made to the use of established procurement procedures. For example, the report notes that the Southern Health and Social Care Trust was an outlier in 2007-08. In 2008-09, it reduced substantially its level of procurement overrides. We have also investigated the reasons for those overrides. Some 80% of them do not relate to the whim of an individual who wishes to use

product A or product B, as might be inferred from the report.

Infusion pumps are an example, which are used by a variety of staff to administer fluids to patients. The National Patient Safety Agency highlighted a potential for improvement in standardising those devices so that a nurse would not find a certain device in ward A and a different device in ward B. The majority of recent procurement overrides have been on the grounds that it is important to standardise clinical devices. As we step back from that, we need to ensure that our contracting strategies take account of that in the future. In recent times, we argued that it is important to standardise the equipment on wards, and even if product A is a little more expensive than product B, standardisation is a reason to override that in the short term.

Although we are not complacent about the level of those procurement overrides, there has been a dramatic reduction. We know the underlying reasons, and we are confident that the majority are for good clinical reasons. However, we will continue to examine our contracting strategies and ensure that it is not necessary to have a procurement override for standardisation reasons.

The Acting Chairperson:

Are savings being made from that process?

Mr Donaghy:

In respect of procurement?

The Acting Chairperson:

Yes.

Mr Donaghy:

Significant savings are targeted for procurement as part of the three-year comprehensive spending review.

The Acting Chairperson:

Will you give us a list of the savings for which you are aiming? Is there a projection?

Mr Donaghy:

Absolutely. I do not have those figures to hand, but I am happy to provide the Committee with details of the work for the standardisation of clinical products and the subsequent savings from contracting for a single product instead of multiple products.

The Acting Chairperson:

That would be super.

The Department has a drive towards openness and transparency. In 2007-08, at least three senior executives in the Northern Health and Social Services Board refused to give details of their salaries; senior consultants have to disclose their salaries. Has any action been taken to ensure that senior executives cannot get away with not disclosing their salaries? It is vital that there is openness and transparency.

Mr Donaghy:

Action has been taken. On a point of accuracy: consultants are not required to disclose their salaries; the disclosure requirement applies to the directors of organisations. The report states that it was "curious" that three people managed to use the exemption protocol and refused to declare their consent. For that to be signed off, it had to be approved by the board of the organisation. The report notes as "curious" the fact that the board saw fit to apply that exemption in those three cases.

We do not anticipate a repetition of that. On every occasion, an employment contract is placed anew to make it a condition for people taking up a senior appointment to be prepared to disclose salary information in accordance with good practice. Those three individuals from the Northern Board are not currently in Health Service employment. It was their personal decision, supported by their board at the time. We agree that that is not helpful, and we do not expect a repetition, and we have used the vehicle of contracts to ensure, as far as possible, that that is the case.

The Acting Chairperson:

Did you say that consultants do not have to declare their salaries?

Mr Donaghy:

Individual consultants are not required to declare their salaries.

The Acting Chairperson:

Why are they exempt?

Mr Donaghy:

The requirement to disclose salaries, which is based on the Cadbury principles, relates to the most senior employees of an organisation, such as those who operate at board level or thereabouts. Given that those individuals potentially have the capacity to control their own remuneration, the duty for transparency and openness states that those should be revealed.

There are hundreds of consultants. Although they are senior people who have a critical role to play, they are not usually responsible for running organisations. Their salaries are set with reference to national frameworks, and they do not have an opportunity to influence their salaries. My reading of why we require senior directors of organisations to disclose their salaries is because it is an additional check and balance to ensure that the earnings that are made at that level are reasonable and proportionate. Consultants do not direct those organisations; they are employees, albeit very important ones.

Mr Buchanan:

Cleanliness has been, and continues to be, a big issue for hospitals. Paragraph 4.3.1 of the report refers to the setting up of standards and controls. However, paragraph 4.3.4 states:

"More needs to be achieved, particularly in the areas of emergency planning, records management and environmental cleanliness."

That suggests that more standards will be put in place to measure cleanliness. That paragraph also states:

"the Regulation and Quality Improvement Authority has recently reported that maintaining cleanliness continues to pose a significant challenge for Northern Ireland hospitals".

Paragraph 4.3.4 further states that trusts that achieve 70% of the overall level of compliance are classed as having achieved "substantive compliance". It is somewhat ironic that resources are being directed towards the establishment of standards rather than ensuring that trusts are complying with them. Given that trusts must achieve only 70% compliance to achieve substantive compliance, is there not a danger that some trusts are failing to maintain the basic cleanliness that is required in the Health Service? Is there also not a danger that, in setting

standards, resources are being directed to the wrong areas?

Mr Donaghy:

I will deal with your point about the setting of standards, and my colleague Dean Sullivan will deal with the progress that has been made on improving cleaning standards.

There are 22 standards, which are based on the most objective processes that we can identify, including self-assessment and third-party verification, to ensure that there is no picking and choosing to allow a score of 70%, for example, while masking a substantial area of non-compliance. That said, no standard is perfect, and no generic standard can guarantee that one will not find certain areas that cannot be improved on. The RQIA has played an important role in ensuring that there is a process of checking the environment on the ground and ensuring that that tallies with the information that we find via the standards.

We are confident that the standards have brought about improvements. However, we do not rely on them exclusively, and we still check what is happening on the ground. The RQIA has played an important role in that regard, as it did in its reviews of healthcare-acquired infections and the outbreak of clostridium difficile. It set an agenda for improvement. We are pleased that the RQIA is available to do that. We use that agenda for improvement to ensure that there are real environmental improvements on the ground, which should promote better scores in the biannual assessment process. It is not one or the other; both are required. I hope that priorities are not being skewed towards the process of improving the environment rather than actually improving the environment. We need to do both.

Mr Dean Sullivan (Department of Health, Social Services and Public Safety):

Mr Buchanan made a fair point that we need to be, as Sean said, wary of the risk of the process dominating the outcome. In fact, we are very wary of that, and we have put in place a number of processes in this space in addition to the controls assurance standards on environmental cleanliness. Moreover, the RQIA carries out its reviews, and the Public Health Agency takes forward processes as part of the drive to reduce healthcare-associated infections. The Department's Cleanliness Matters strategy also provides assurances on those standards.

The Committee will be aware, in the spirit of ensuring and assuring that those processes are coherent, that they stack together and that they are proportionate, the Minister launched a process

at the end of 2009 after the latest round of RQIA inspections. A key element is to examine the suite of standards and guidelines at our end to ensure that that we have a single view of "clean" and "hygienic" that all parties understand and work towards. The outworking of that may require some tweaking in the controls assurance standards or in other elements of the assurance framework in light of the views of stakeholders and the latest available evidence. Therefore, Mr Buchanan's comment is fair, but I reassure the Committee that we are acutely aware of that issue and that we are addressing it as we speak.

Mr McDevitt:

I still find it difficult to get my head around the fact that, between October 2006 and December 2007**,** the Western Trust — or, rather, the former Sperrin Lakeland Trust — incurred £2·4 million of expenditure for specialist advisers without business case approval. There is not much detail about the nature of that expenditure in the report, except that it appears to have gone on associated project management costs. Can you provide us with specific details of how that money was spent between October 2006 and December 2007?

Mr Donaghy:

There is no doubt that £2·4 million is a large amount of money. The Committee has previously questioned the scale of that expenditure. It relates to the new Erne Hospital and the associated preliminary work. It was a private finance initiative (PFI) project. I will not go into too much detail, except to say that those projects have significantly higher overheads to mobilise and agree than conventional projects. One recognised facet of PFI projects is that they incur significant expenditure on financial and accountancy consultancy; on preparing a scheme for market; and on negotiating with the range of bidders who are present. That is done in a legalistic environment, which creates significant overheads for all PFI projects.

However, it is unacceptable that business case approval was not in place. The Department of Finance and Personnel (DFP) subsequently agreed that all that expenditure was proportionate and appropriate, but that the trust should have made a prospective application for approval. There was nothing to suggest that the expenditure was improper or that it would not have been incurred in any event. The trust's failure was that it did not make that application to the Department in due course and that the Department did not, in due course, ensure that there was speedy application to DFP to clear the appropriateness of that expenditure. As I have said, therefore, it is important that members are assured that there was no waste of public money: DFP took the view that the

expenditure was, indeed, appropriate. The problem was the absence of prospective approval.

I can provide more detail of elements of that £2·4 million. However, the fact that the figure is scaled so high is primarily attributable to the fact that it was a PFI project, which had associated overheads, such as the cost to negotiate with the private sector in a legalistic environment.

Mr McDevitt:
Can you provide us with a breakdown of that £2·4 million now?

Mr Donaghy:
I am afraid that I am not equipped to give you a detailed breakdown of the £2·4 million now. It is a component of a cost. It is one element that was deemed not to have been approved. The overall overheads for that project are substantially higher than that figure.

Mr McDevitt:
I understand that.

Mr Donaghy:
I can provide details for the project's overall overheads in due course. However, I am afraid that I do not have those details with me today.

Mr McDevitt:
The report is not clear about how the approval mechanism failed when, in fact, it appears that the Department was aware that that expenditure was being incurred at the time. Therefore, it appears that the Department was conscious of that happening, but, for some reason, procedures that one would have expected to follow that awareness were not activated.

Mr Donaghy:
Procedures to ensure that there was timely and prospective approval of management consultancy expenditure needed to be revisited. There was a presumption on the part of the trust and, subsequently, on the Department that, given that they were clear about the nature of the expenditure and had satisfied themselves about its appropriateness, there would have been no difficulty with regard to clearance. DFP, quite rightly, said that approval must be prospective. For that reason, there was a failure and, therefore, a refusal on our part to approve that

expenditure in retrospect.

We are confident that the procedures that we have put in place since then make it unequivocal that no project can progress without clear prospective approval. We do not expect to see repetitions of that nature. One further instance occurred during the following year, which related to the Northern Ireland Blood Transfusion Service (NIBTS). The report also draws that out. We are clear that it is unacceptable to go ahead and incur expenditure ahead of time.

Mr McDevitt:

I intended to raise the Blood Transfusion Service as another example of a similar type of procedural failing. If my chronology is correct, since late 2008, how many PFIs has the Department managed? How many positive examples are there in which there has not been this type of procedural failing?

Mr Donaghy:

For clarity: the NIBTS example is not a PFI project; it involved the use of a management consultancy within an urgent timescale to address public concerns.

Mr McDevitt:

However, the earlier example was a PFI project.

Mr Donaghy:

It was a PFI project. The Erne Hospital is the only example of a PFI of its scale. There is a range of other relatively minor projects, but nothing on such a scale. There may have been some minor PFI projects since May 2008, but, unlike the Erne Hospital, they have not generated significant overheads related to the use of external management consultancy support. We will have had a wide range of external management consultancy reports, but not in relation to PFI projects. I could not quote a precise figure; however, I am happy to obtain and provide it, and to assure the Committee that we have not had retrospective approval or projects starting before approvals were properly in place.

Mr McDevitt:

I have one quick question about the savings that trusts were expected to generate under the review of public administration (RPA). In September 2009, the Minister's reply to a question for written

answer from Kieran McCarthy of the Alliance Party stated:

"Trusts have been set targets totalling £38.2m recurrently (or £93.8m in total across the current CSR period) out of Trust budgets as their contribution to the overall RPA target of £53m recurrent savings. The remaining £14.8m savings will be found from the HSCB, PHA and BSO and the implementation of shared services."

In light of what has happened to public finances since September 2009, can the Department still stand over that answer?

Mr Donaghy:

What has happened since September 2009?

Mr McDevitt:

There has been an obvious tightening of public finance, which relates to efficiencies in the CSR commitment as it was in September; therefore, is that answer still valid?

Mr Donaghy:

Yes, it is. There has been no loosening of, or rowing back from, the scale of the savings that the Department is targeted to achieve by March 2011. The progress that has been made in reducing some 1,669 posts to generate that £53 million in savings is proportionate to our ambition to achieve it in full by 2011. If anything, the economic crisis or crunch has redoubled our determination to provide services from administrative, overhead and back-room staff — a term that I am always reluctant to use for staff in central jobs such as finance and HR — as cost-effectively and to as high a quality as possible. Doing so entails making savings over the RPA period.

Mrs D Kelly:

I want to pick up on Tom's point on the cleanliness reports. Is there a link between the reports and the health estate being up to standard? Is there a backlog of repairs? Is new capital expenditure required? Are there any risks of any organisations or member groups breaking any health and safety law by failing to comply with regulations?

I share Tom's concerns about the service being process-driven rather than focusing on outcomes or compliance. I am also concerned about the number of bodies that are not making the grade in health and safety, emergency planning and records management. Given the level of concern about data loss in relation to the swine flu pandemic, has the situation improved?

Mr Donaghy:

I am sorry; I am not sure that I follow your last point, and I want to ensure that I pick it up properly.

Mrs D Kelly:

My question concerned emergency planning and records management. Given the backdrop of swine flu and high-profile media reports of data loss, and in the light of figures 5 and 7 and paragraph 4.3.4 of the report, has performance improved since then? If not, why not?

Mr Donaghy:

In a moment or two, I will hand over to Dean, who will provide an update on progress on emergency planning, which is particularly important in the context of swine flu, and on records management.

The patent need for investment in some significant areas of the health and social care estate is well documented. I am struggling to recollect the precise timelines, but, in the first version of the investment strategy for Northern Ireland, the health and social care sector stated that it needed three or four times more investment in its estate than the funding that has subsequently been made available. Therefore, there is an absolute need to consider the estate, to ensure that we take as balanced an approach as possible to managing risk and that we apply the available funds judiciously to those risks as they arise. I cannot assure the Committee that no risk will arise. However, I can provide an assurance that proportionate risk-based systems are in place to identify risk. We will target our efforts on that risk when it arises.

Trusts and, ultimately, their boards and chief executives, who act as accounting officers, have a duty to declare those risks. Part of the fundamental purpose of the statement of internal control is that trusts must declare any risk to the safety of patients, staff or the public at large to ensure that there is no doubt that the risk exists. Thereafter, the challenge is how to resource and fix that problem. We do not want someone to hide a problem for want of the resources to fix it. The risk management process is in place to expose the risks and ensure that, however difficult the choices on prioritisation are, one must make those choices. Such decisions are made all the time, and they arise by virtue of the fact that we do not have sufficient capital investment to replace our estate in the way that we want to. Therefore, we must immediately move into a risk management process and make tough choices across the estate.

Mrs D Kelly:

An update on investment strategy bids would be interesting, because the priority for the Executive and for government in the North is to front-load infrastructure and help to kick-start the construction industry and other industries. That impacts on the Department.

The Acting Chairperson:

The Committee is due to receive a briefing on the capital infrastructure programme in May. Are you happy to wait until that time, Dolores?

Mrs D Kelly:

Yes, that is fine. I suspect that May will come round very quickly for some of us.

Mr Donaghy:

Mrs Kelly asked about compliance. We are also wary of burdening organisations and individuals with processes that distract from the real job of ensuring that the environment and the services are fit for purpose. However, for the reasons that Mrs Kelly outlined, it is equally important to require organisations to assess their environment and service systematically and to ask whether they face risk and, if so, what they are doing to mitigate it. Dean will respond to the question about emergency planning and records management.

Mr Sullivan:

I will deal with emergency planning first. As members will expect, all health and social care organisations trawled through their emergency planning arrangements with a fine toothcomb for five or six months last year as part of the swine flu preparation. Each organisation was required to assess itself and be assessed against a comprehensive framework to provide organisations and to provide us at the centre with an assurance that they were ready for the expected pandemic.

The organisations underwent two or three cycles of that, and, at the end of the process, a high level of assurance and compliance was evident across Northern Ireland, certainly in the case of all the large provider organisations, the six trusts, the Blood Transfusion Service, and so on. That process will continue; the pandemic has not gone away. As members will have seen in the press, there is a risk that it could resurface next winter. Therefore, we will stay on our toes and be on our guard to ensure that those arrangements remain up to date.

Mrs Kelly asked about records management. That is a priority in the Department. Earlier in this financial year, we wrote to all trusts and other bodies to advise them of their responsibilities on records management. DFP is leading a process across all Departments, which specifies the requirements, controls, and so on, that it expects to see in place. We are working with our arm's length bodies to ensure that the right processes are in place to meet those requirements. There are areas in which we need to improve, and we are not unique in that. As we look across the patch at experiences elsewhere in the UK, we see that there are challenges in that area. However, I assure the Committee that it is a high priority for the Department, and we are ensuring that it is given an appropriate priority by all the bodies within the Department's remit.

Mrs D Kelly:

Has the person-centred community information system (PCIS) been abandoned by the Government.

Mr Donaghy:

The scheme has been formally stood down. The view was taken, given the readiness of the suppliers at the point where the project was to close and to make an award, that the award that it would have made might not have been deliverable, given the changes that took place among the supplier base at that time. Significant benefit was extracted from the scheme that had taken place up until that point, and considerable progress was made in a number of trusts where pilots were being conducted. We continue to learn from those to do all that we can with the investment that was applied there and to ensure that there is clarity about the best community information systems that we can obtain. However, the formal scheme to award a PCIS contract was stood down because of concern that the suppliers would fail.

Mrs D Kelly:

Based on the electronic planning information for citizens (e-PIC) project and the Planning Service overspend, how much money was spent on work for the computer system?

Mr Donaghy:

It was not actually procured because it was stood down pre-procurement.

Mrs D Kelly:

Many staff were involved.

Mr Donaghy:

I do not have those figures to hand as it was not a question that I was prepared for.

Mrs D Kelly:

It is good management to have records.

Mr Donaghy:

I am happy to respond to the Committee on that.

Mrs McGill:

Mr McDevitt raised some valid queries about the situation in the Western Trust. At this stage, it is quite difficult to understand what happened. The deficit that was carried over from the Sperrin Lakeland Trust to the Western Trust was between £2 million and £3 million.

Mr Donaghy:

The figure is £3·4 million.

Mrs McGill:

Does that figure relate to the report's comments about specialist advisers and consultants, or does it relate to something else?

Mr Donaghy:

No, it does not. Although attempts were made to attribute the £3·4 million to specific components of costs, none of them was in relation to the bill for specialist advisers, and so forth. That was funded fully and was budgeted for in advance. The failing was the prospective approval from the Department of Finance and Personnel.

Mrs McGill:

Are you saying that the huge deficit of almost £3 million that the Western Trust acquired from the merger with the Sperrin Lakeland Trust had absolutely nothing to do with the appointment of consultants and specialist advisers?

Mr Donaghy:

I do not have the details of the deficit that was faced by the former Sperrin Lakeland Trust. On a point of accuracy: the Department waived the £3·4 million deficit, and the Western Trust was not required to recover it. At that time, the Department said that it was important for the trust to break even, and if the trust did so, it would waive the deficit. About a year ago, the Minister announced that that was the case. Whether any component of the expenditures related to the new Erne Hospital, I would not want to say no, absolutely and incontrovertibly. However, I assure members that the conclusion that £2·4 million was not properly approved had nothing to do with budgetary provision for it. There was budgetary provision for the expenditures for necessary PFI work for the Erne Hospital.

Mrs McGill:

The Minister waived the deficit, but only up to a point. If the Western Trust were able to break even, as you say, on the 3%/efficiency savings, the Minister and the Department would not be looking for £3 million. The Western Trust had to work exceptionally hard in order for that £3 million not to have to be paid back.

Mr Donaghy:

I accept that, although it is important that all organisations break even.

Mrs McGill:

It is a moot point that you make. In any case, you are saying that none of that £3 million went towards paying the specialist advisers and the management consultancy.

Mr Donaghy:

I am saying that that was budgeted for.

Mrs McGill:

In the report, specialist advisers and management consultancy are considered separately, and there are two sets of figures. The £2·4 million for the specialist advisers is separate from the management consultants; Mr McDevitt raised that point. Was the £2·4 million the amount that was approved subsequently by the Department of Finance and Personnel, is it the figure for the management consultants, or was it all approved?

Mr Donaghy:

The key point is that the £2·4 million approval was withheld by the Department of Finance and Personnel. I was trying to emphasise earlier that at no point was it suggested that any of the expenditures were improper or that there was any waste of public funds. However, the valid point was made that there should have been prospective approval, and, in the absence of that, DFP withheld approval. As a result, the accounts of the Sperrin Lakeland Trust were qualified in respect of that as being unauthorised expenditure, and it was a note to the Department's accounts also. That was the effect of it, to say that the trust spent money that was not fully authorised. There was feedback stating that, had the case came in due course, it is likely that it would have been fully approved. The failure was the timing of the application for approval, not the nature of the expenditures incurred.

Mrs McGill:

In relation to the management consultants, paragraph 5.3.2 of the report states:

"The circumstances in which the consultancy was procured are unclear and no documentary evidence was made available to us to demonstrate that the appointment was in line with the regulations."

To some extent that was in the past, but it is fairly damning.

Mr Donaghy:

It is; absolutely.

Mrs McGill:

It is in black and white. No evidence was given, and it is unclear how all this came about. Are you saying that all that has now been sorted, that the protocols and processes that are now in place have taken account of that and that the Department is now in a position where that will not happen again?

Mr Donaghy:

We are in a position to offer an assurance that we have done all that we can to prevent a recurrence. I would be disappointed and surprised if there were a recurrence. However, we are dealing with human beings, and there is no guarantee that human beings will always apply the processes, protocols and governance that we put in place perfectly. However, the approval processes have certainly been strengthened, and we are confident that they should prevent a

recurrence. They do not excuse the failings that you have mentioned. We cannot fix that — those failings are now a matter of public record — but we have certainly taken account of them to ensure that the systems are robust enough to prevent a recurrence.

Mr Buchanan:

I want to make one comment on that matter. Is the overspend of £2·4 million not a clear indication of mismanagement by the Sperrin Lakeland Trust?

Mr Donaghy:

The Department has already reached the conclusion that allowing the trust to overspend by £3·4 million constitutes mismanagement. That happened in the final year of that management unit, and it was subsumed immediately thereafter — on 1 April — into the new Western Trust, hence Mrs McGill's comments about carrying forward penalties, and so forth. However, that trust ceased to exist on 31 March 2007. Nevertheless, I would in no way defend as appropriate management anyone allowing a deficit of that scale to be incurred. It is, indeed, poor management.

Mr Buchanan:

The political representatives in that area and the new Western Trust had a fierce battle on their hands with the Minister in order for the overspend to be wiped out from the Western Trust's accounts for that year. The trust had a hard job to break even so that it would be cleared from its accounts.

Mr Donaghy:

The trust worked hard to recover the difficult situation that it inherited on 1 April 2007. Nonetheless, it was always the expectation that it would break even: that was the standard that was set. Depending on one's perspective, it is either an added threat or an additional opportunity to say that, by breaking even, a deficit from delivering services to the people of the west would be wiped clear. Effectively, if there is an overspend in services in one area, that funding for services is not available to the residents of the rest of Northern Ireland. Therefore, when we consider deficits, it is important to ensure that, as far as possible, there is equity in how we deal with those deficits. Nevertheless, given that it was a brand-new trust and that it was clear that it was a hangover from a previous organisation, an exception was made. The normal view should be that the deficit must be cleared by some means. Therefore, if a clean sheet could be maintained, the

debt would be carried by the Department of Health, Social Services and Public Safety.

Mr Buchanan:

What will happen to the trusts that do not break even at the end of March 2010?

Mr Donaghy:

That is a matter for the Department to determine in due course. It is already a matter of record that one trust faces significant financial problems at this stage. The Department will consider how to manage those financial problems up to 31 March 2010, and it may make funds available to those trusts in the context of being very clear about whether those funds are a one-off support for real problems faced to allow break-even to be achieved. However, that matter has not been resolved, and we are still negotiating and holding to account all trusts against a target of breaking even.

Mr Gardiner:

Is that as a result of bad management?

Mr Donaghy:

To which element are you referring?

Mr Gardiner:

I am referring to the overspends.

Mr Donaghy:

There are significant stresses and strains on health and social care services at this point. We have had significant increases in the level of demand for services, and we continue to assess regularly the extent to which the problems that are manifesting themselves financially can be attributed to additional services being delivered by trusts. Nonetheless, the public sector must live within the available resources. We must reach the stage at which all trusts and organisations are living recurrently within the resource envelope that is available to them. At this point, I would not condemn any trust's management to date. They face significant pressures, but it would not be allowable over time for trusts to spend more resources than the public sector has funds available for those services.

The Acting Chairperson:

Thank you, Sean, Dean and Jim for your presentation. I hope that you enjoyed yourselves.

Mr Donaghy:

I have a couple of brief comments. The first is a point of accuracy, and the second is a little bit of loose language on my part that I wish to correct.

PCIS was stood down in relation to concerns about the robustness of the supplier base. I think that I used different language that was inappropriate, and this is the language that I want, if possible, to leave you with.

Mrs D Kelly:

I know what the trusts used to call PCIS.

Mr Donaghy:

With regard to the assurance that I gave to Mr McDevitt on RPA savings and their achievement by 2011, there is one component that will not deliver by 2011, and that relates to shared services. There was a £30 million capital investment programme required to allow shared services to deliver in due course. The business case was recently completed, and we have to undergo a lengthy process to deliver that investment. The shared services element will extend beyond 2011, but the Department acknowledges its responsibility to find other savings to make up the difference up to 2011. However, I considered shared services earlier today, and it occurred to me that it will not deliver by 2011. That accounts for some £4 million of the £53 million.

Mr McDevitt:

Thank you for that information.

The Acting Chairperson:

Thank you very much.