Comptroller and Auditor General
Special Report

Department of Health and Children

Health Sector Audits

August 2004

This report was prepared on the basis of information, documentation and explanations obtained from the public bodies referred to in the report. A draft of the report was sent to the Department of Health and Children, the Eastern Region Health Authority and the Health Boards. Where appropriate, the comments received from the Department, the Authority and the Boards were incorporated in the final version of the report.

Special Report of the Comptroller and Auditor General

Health Sector Audits

I have, in accordance with the provisions of the Comptroller and Auditor General (Amendment) Act, 1993, prepared a special report on general matters arising out of audits of bodies in the health sector.

I hereby submit my report for presentation to Dáil Éireann pursuant to Section 11 of the said Act.

John Purcell
Comptroller and Auditor General

5 August 2004

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1 Health Sector – Outturns and Outputs

Sector Expenditure

1.1 The net expenditure on the health service increased by 169% between 1995 and 2002. This increase outstripped the provision on other public services by a considerable margin. The movement in the costs of the service and in income generated is set out in Figure 1.1.

Figure 1.1 Health Expenditure 1995 and 2002

	1995 €m	2002 €m	Increase
Pay	1,910	4,859	154%
Pay Related Expenditure[a]	279	858	207%
Non-Pay Costs	916	2,450	167%
Gross Expenditure[b]	3,105	8,167	163%
Income generated by health boards	186	300	61%
Net Expenditure	2,919	7,867	169%

Source: Department of Health and Children
Note a Pay Related Expenditure includes the pay element of grants to agencies subvented by the Department and fees to doctors and pharmacists.
b Includes net expenditure from the Health Vote and Health Board expenditure funded by their own resources.

1.2 Not all health programme costs increased at the same rate. Increases in individual programmes ranged from 95% in the case of the Mental Health Programme to 350% in the case of the Community Protection Programme. The cost movements on health programmes between 1995 and 2002 is set out in Figure 1.2.

Figure 1.2 Expenditure by Programme 1995 and 2002

Programme	1995 €m	2002 €m	Increase
General Hospital Programme	1,557	3,802	144%
Community Health Services Programme	516	1,526	196%
Disability Programme	327	963	186%
Mental Health Programme	289	564	95%
Community Welfare Programme	229	704	207%
General Support Programme	126	333	165%
Community Protection Programme	61	275	350%
Total Expenditure	3,105	8,167	163%

Source: Revised Estimates for Public Services, 1996 and 2003, Department of Finance.

1.3 Apart from the effect of general and special pay increases which were particularly high in the period under review, the rise in pay costs over the period was also influenced by an increase in numbers employed. Figure 1.3 sets out the estimated increase in staff numbers by category over the period.

Figure 1.3 Staff Numbers 1995 and 2002

Category of Staff	1995	2002	Increase
Nursing	27,267	33,395	22%
General Support Staff & Other Patient Care	19,558	27,242	39%
Management & Administration	7,904	15,690	98%
Health and Social Care Professionals	5,345	12,577	135%
Medical Dental	4,581	6,775	48%
Total	64,655	95,679	48%

Source: Department of Health and Children

1.4 There has been some change in the staffing structure over the period.

- The use of agency nurses, which had been relatively rare in 1995, had become a significant resource by 2002. These numbers are not, however, reflected in Figure 1.3 because they are not readily available.
- Certain grades of staff, including paramedical and some support staff, now undertake certain duties previously performed by nurses.
- Around two-thirds of support personnel are involved in front line patient services, for example community welfare officers and secretaries to consultants.

Acute Hospital Expenditure

1.5 The Eastern Regional Health Authority has recently analysed the causes of the expenditure growth between 1998 and 2002 in the Dublin Academic Teaching Hospitals (DATH).[1] Gross expenditure increased by €425.5 million, from just over €500 million to over €925 million, in the 5 years reviewed. The major elements of this increase were as follows

- 3,000 additional staff, substantially medical, costing €104.5m
- Pay awards of €152.5m
- Clinical supplies €112.5m
- Facilities management including heating and maintenance €20.2m

1.6 The hiring of additional staff contributed to an increase in the number of patients treated in these hospitals, during the five-year period, from 174,000 to 225,000 – an increase of 29%. A substantial number have been in the high cost areas of cancer care and haematology. Outpatient attendances have increased by 31% since 1999 – from 533,000 to 700,000.

1 The Mater, Tallaght, Beaumont, St Vincent's and St James's hospitals.

1.7 Significant activity increases in the 5 years were

- 147% increase in Haematology admissions
- 116% increase in Cancer admissions
- 77% increase in Gastro-enterology admissions
- 24% increase in Cardiology admissions
- 24% increase in Cardio-thoracic surgery

1.8 The €112.5 million (100%) increase clinical supplies expenditure can be attributed to

- 281% growth in expenditure on blood – the most significant cost increase in the period was largely due to the use of highly expensive blood products for the National Hemophilia Programme operated at St James's Hospital. Significant price increases in blood were incurred because of new safety requirements around transfusion, increased transplantation and expanded and more aggressive cancer treatments.
- 95% growth in expenditure on drugs and medicines was largely due to the introduction of new antibiotics, cancer treatment, rheumatoid arthritis treatment and infection control for MRSA[2] and other resistant micro-organisms.
- 53% growth in medical/surgical supplies expenditure driven largely by the introduction of new technologies.
- 44% growth in X-ray/imaging expenditure due to higher clinical activity, new methods and clinical practice, increased day surgery and ambulatory care. The period under review has also seen the development of public Magnetic Resonance Imaging (MRI) services in the Dublin region.
- 54% increase in laboratory expenditure.

1.9 By 2002, €14 million was being spent by the DATHs on ten major drugs. The expenditure on these drugs reflects the following clinical medicine and service trends

- Growth in the use of powerful antibiotic drugs to treat specific diseases and in use with cancer patients
- Growth in the availability and access to cancer treatment drugs
- Development of new drug therapies for treatment e.g. for rheumatoid arthritis
- Large growth in the use of infection control agents which has occurred throughout the Dublin hospitals due to MRSA and the other resistant micro – organisms.

Health Outputs – Hospital Services

1.10 Health boards report that hospital activity levels, measured in terms of patient discharges, have increased consistently over the period. They estimate that by 2002 discharges were around one million for that year. There has been an increase in the volume of work due to the continued demand for services such as cancer, ENT and maternity services. This has led to expansion of consultant medical teams, the development of high-tech laboratory and diagnostic services and

2 Common bacteria, resistant to antibiotics.

investment in new drug therapy services. New and expanded services have been brought on stream in the following areas

- cardiovascular services
- transplant services
- renal services
- genetic services
- cancer services
- neurology services

1.11 The boards also report that hospitals have been dealing with increasing numbers of older persons who require a higher intensity of services. To respond to the needs of this group, health boards and hospitals have employed increasing numbers of geriatricians to assist with the care of older persons. Over the period, the range and type of maternity and paediatric services have also expanded.

1.12 As a result, hospital throughput has risen over the period. Throughput increases have been achieved by reducing the average length of stay. The number of new acute beds has increased only marginally. Hospitals now have high occupancy levels with the number of bed days used almost doubling over the 1990s. Hospitals have continued to open more day surgery beds as new technology and techniques have allowed cases to be dealt with in such environments.

1.13 In the mental health services, the number of in-patients decreased from 5,807 to 3,891 between 1995 and 2002. Care delivery has transferred over recent years from large psychiatric institutions to new acute units and facilities in communities.

1.14 Cancer services have been expanded with the appointment of 90 consultants and 245 clinical nurse specialists since the introduction of a national cancer strategy in 1997. Capital funding has been applied towards Radiation Oncology (€54m), a Bone Marrow Unit in St James's Hospital (€9m) and a national breast screening programme which is being developed.

Trends in Care Services

1.15 The Department's Health Strategy sets out a long-term programme of investment and reform. The programme aims to provide 3,000 new acute beds over the period to 2011. The Department has been informed by the Eastern Regional Health Authority and the health boards that, to date, 568 additional beds have been commissioned.

1.16 The National Treatment Purchase Fund (NTPF) is being used for the purpose of purchasing treatments for public patients who have waited longest for treatment. Some €31 million was provided in 2003 for the NTPF and available capacity has been identified in different specialties in Ireland and the UK to treat those eligible.

1.17 Investment has been made in drug treatment services in communities with the purchase of local clinics and the development of multi-disciplinary teams consisting of professionals such as

counsellors who assist the long-term recovery of clients. By 2002, 6,500 attendances were being registered in Drug Treatment Centres compared with 4,400 in 1995[3].

1.18 The number of infectious diseases dealt with by health boards is increasing. The increase in these diseases has necessitated the development of facilities such as the National Disease Surveillance Centre, the development of public health screening and monitoring services and the provision of specialised services such as clinics to deal with sexually transmitted disease (STD) and HIV/AIDS counselling services. 9,703 STDs were notified in 2002 compared with 5,144 in 1995[4]. New cases of HIV and other infectious diseases were arising at an increased rate.

1.19 There were 25,448 persons classified as having intellectual disability in 2002, a fall of around 6% since 1996[5]. Over 5,000 of these have severe or profound disabilities. A range of disability services has been developed by health boards including residential services, day services and support employment schemes. Although no figures are available for persons with physical and sensory disability, equivalent service needs have been required to be met for this group of clients also.

1.20 The number of eligible persons on the General Medical Services Scheme (GMS) has decreased slightly from 1.22 million to 1.16 million in the period 1997-2002. Since July 2001, all persons over 70 have a statutory entitlement to a medical card.

1.21 Expenditure under the GMS and related schemes has increased as outlined in Figure 1.4

Figure 1.4 General Medical Services and Related Scheme Costs 1997 and 2003

	1997	2003	Increase
	€m	€m	
GMS	361	1,023	183%
Community Drugs Scheme	86	282	228%
Long Term Illness Scheme	30	54	80%
Hardship Scheme	7	30	329%

Source: Department of Health and Children

1.22 Services have been expanded in the child care area following implementation of the Child Care Act, 1991. New services include

- Child protection services which deal with the investigation and management of child abuse
- Springboard family support services
- High support special care places
- Services to prevent and address youth homelessness
- A Social Services Inspectorate was established in 1999 – it inspects children's residential services and aims to promote and ensure the development of quality standards.

3 National Drug Treatment Reporting System, Health Research Board.
4 Health Statistics, Government Publications.
5 National Intellectual Disability Database, Health Research Board. The National Intellectual Disability Database was established during 1995.

1.23 There has been a 75% reduction in Group C meningitis cases since 1997. Interventions in this area, while not inexpensive, are cost-effective in the long run as they reduce the relevant costs in the acute sector.

1.24 In the disability area, there has been significant increased investment for both the intellectually and the physically disabled, with around 4,000 new residential, respite and day places being provided in the system in the same period.

2 Unauthorised Capital Expenditure

2.1 The day to day management of capital projects and equipping is carried out by health boards. In the case of capital expenditure subvented by the Department, the Department's procedures called for the projects and their funding to be authorised by it in advance. It was noted in the course of the audits of health boards that capital deficits had arisen due to the boards incurring expenditure on certain projects and equipment where funding had not been approved by the Department. The expenditure in question has been initially funded by the boards from revenue moneys drawn down from the Department on a bridging basis. This chapter examines the circumstances surrounding the entry, by health boards, into contractual capital commitments without the prior authorisation of the Department.

National Development Plan 2000 – 2006

2.2 In February 2000, the Department wrote to the health boards announcing the intention to provide capital funds from the NDP. €2.54 billion[6] was to be provided for capital investment in the health sector for the period 2000 – 2006. The Department, in order to implement the investment plan, sought a draft development plan from each health board with a costed set of projects and initiatives listed on a priority basis. Each development plan was to encompass projects in the pipeline from previous years and new capital initiatives going forward to 2006. The NDP was also intended to achieve a funding balance in capital developments between the acute and non-acute sectors.

2.3 As this was the first recourse by the health sector to funds from a national development programme an interim arrangement applied in 2000. Under this arrangement, the Department informed the health boards that the first tranche of funding under the NDP, totalling €293[7] million, was available and advised them that every effort should be made to draw down these funds in line with the normal requirements for recouping capital expenditure.

2.4 In regard to future years, the Department explained that the NDP would bring about a fundamental change in approach in the planning and funding arrangements for future capital expenditure and that 2000 was the start of a transition period from old to new arrangements. It was intended to devolve full responsibility for implementation of projects[8] from the Department to the health boards in March 2001. However, pending the implementation of devolution, the existing arrangements for project approval by the Department would continue to apply and the health boards should not undertake any capital expenditure commitments without the Department's prior agreement.

2.5 Following receipt of the development plans, the Department wrote to the health boards in May 2000 confirming the amount of indicative funding to each board for the period 2001 to 2006. The Department's letter also allocated a separate amount of €71 million in indicative funding specifically for ICT equipment over the period 2000 to 2002.

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6 The €2.54 billion is stated at 1999 price levels. After adjustment for inflators, the amount included in the Economic and Social Infrastructure Operational Programme, for the period 2000 – 2006 was €3.036 billion.

7 Including €19m for Information Communication Technology (ICT).

8 With the exception of general hospitals.

2.6 The indicative funding notified to the health boards is set out in Figure 2.1 below.

Figure 2.1 Indicative Funding per Health Board under the NDP 2001 – 2006

Health Board	Indicative Funding €m
ERHA	776
Midland	158
Mid Western	142
North Eastern	175
North Western	132
South Eastern	199
Southern	294
Western	197
Total	**2,073**

Source: Department of Health and Children

2.7 In addition to the €293 million funding already provided in 2000 and the indicative funding outlined in Figure 2.1, the Department had provided for a further €164[9] million for ICT and €10 million for research funding for the period 2001 – 2006.

2.8 The Department also informed the health boards in May 2000 that, in order to expedite the equipping and refurbishment programme for 2000, the Minister would approve an amount of €91.35 million (€10.15 million for each board and €20.30 million for the ERHA). The funds were part of the overall 2000 voted capital of €293 million and were intended for replacement equipment and refurbishment in the acute and non-acute sectors to allow a substantial programme in both areas to be completed before the end of the year.

2.9 With regard to the overall NDP, the Department reiterated its instructions to the health boards that

- every effort should be made to achieve national spending objectives by programme at the end of the NDP period
- the Department reserved the right to transfer funding, as appropriate, to ensure that national programme targets were maintained
- individual projects planned by each board would be subject to the normal established criteria governing approval.

2.10 During the following months, the Department set about compiling lists of NDP projects and establishing systems to ensure that the projects would be approved and delivered in accordance with the agreed programme. As part of this objective, the Department announced that, in order to facilitate approval, its professional staff would be available, as necessary, to assist each health board in preparing development briefs, budgets and programmes for individual projects. The

9 €19m had been provided for ICT in 2000 while €52m was to be provided in 2001 – 2002 and a further €112m in the period 2003 – 2006.

Department also set about establishing an agreed system, common among all parties, for monitoring and reporting on the NDP for its duration.

2.11 By February 2001, the Department had advised the health boards of the NDP funding tranche available for 2001 and asked the boards to provide a revised overall NDP plan before the end of that month. The revised plan was to

- show capital project priorities within the overall indicative NDP funding limits
- take account of the Department's approval criteria, including close liaison with the relevant line divisions of the Department
- adhere to the national objective of equalising NDP funding between the acute and non-acute sectors over the NDP period
- adhere to the standard approval and accounting procedures.

2.12 The Department also advised the health boards that it had appointed a consultant to undertake an analysis of the requirements and specifications of a new NDP reporting and monitoring system and that the consultant would hold detailed consultations with each health board on the matter.

Unapproved Contractual Commitments

2.13 In July 2001, the Department advised the health boards that its representatives would be visiting them to validate the data supporting the revised NDP plans. The Department requested that appropriate staff be available to provide explanations and that the data intended for validation be submitted to the Department at least two weeks before the meeting. The data specified included

- Option Appraisal
- Department approval (where applicable)
- Project programme
- Design brief/Schedule of accommodation
- Cost limits
- Estimated final cost and year-by-year cash flow forecast, including allowance for inflation.

2.14 In December 2001, the Department wrote to all health boards, announcing that the NDP was under review and that, from 2002 onward, there would be a number of changes in how NDP funding would be provided. The Department has informed me that these changes arose out of budgetary adjustments made at national level in order to

- fund expenditure on a Social Housing Programme
- meet the cost of a Nursing Degree Programme
- take account of the impact of inflation on the purchasing power of the NDP provision.

2.15 By late 2001, it became apparent that unauthorised contractual commitments had been incurred by some boards. A pattern began to emerge where demands for reimbursement of capital spending were being made by health boards in instances where no approval had issued.

2.16 The Department concluded after a validation visit to one health board that, given the scale of the work involved, continuing once-off validation visits to boards would be of limited use. The

Department decided that the detailed information needed would require a longer and on-going process over many months in order to clarify the exact position in each health board and the financial and procedural position in comparison to the Department's requirements.

2.17 On 7 February 2002, the Department wrote to the health boards directing them not to enter into further contractual commitments for capital projects without the Department's prior approval. From early 2002, the Department set about surveying each of the health boards on a project-by-project basis.

2.18 In August 2002, the Department again wrote to the boards stating that its review of NDP commitments had revealed significant commitments beyond those approved and reiterating the prohibition on boards entering into contractual commitments without the Department's prior approval.

2.19 The data returned by the health boards showed that they had entered into unauthorised commitments in the following types of cases

- projects which had never been submitted to the Department for approval
- approved projects where additional commitments were made without Departmental authorisation. Those additional commitments on authorised projects arose from scope and design changes and, in certain cases, from incurring cost on projects that had been approved only for annual grants in prior years.

2.20 The Department sought more detailed information on projects giving rise to unapproved expenditure and this information was returned by the health boards in November 2002 in data sheets designed and supplied by the Department for that purpose. After consideration of the data returned, the Department estimated that unapproved contractual commitments in respect of healthcare facilities were of the order of €115 million. This estimate did not take account of additional commitments in respect of offices and certain other facilities[10].

2.21 The Department's review of the data sheets sought to assess each project, to ensure confirmation at CEO level from the health board, and establish the level of unapproved expenditure which the Department could agree to fund.

Funding of Unapproved Commitments

2.22 From the assessment of these returns, the Department identified an amount of €93 million in expenditure arising from unapproved commitments by the health boards, that it was willing to reimburse to the boards at that time. The expenditure reimbursement related to projects assessed by the Department and considered to be specific projects for which the unapproved contractual commitments had been entered into prior to 7 February 2002 and for which cash had been expended up to 31 October 2002, and which were projects appropriate for NDP health capital funding.

2.23 Of the €93 million identified, €35 million related to expenditure on projects not approved at any stage, €32 million related to unauthorised cost overruns on approved projects and €25.5 million related to unapproved equipping expenditure.

10 See Chapter 7 for information on the provision of certain headquarter buildings.

2.24 The outcome of the Department's review of the unapproved expenditure to be reimbursed at December 2002 is summarised in Figure 2.2.

Figure 2.2 Unapproved Capital Expenditure Identified by the Department for Reimbursement to the Health Boards in December 2002

Health Board	Over-Expenditure on Approved Projects €m	Expenditure on Unapproved Projects €m	Unapproved Expenditure on Equipment €m	Total €m
ERHA	10.74	4.33	0.00	15.07
Midland	0.00	4.21	1.45	5.66
Mid Western	1.65	0.00	0.00	1.65
North Eastern	9.44	6.28	9.67	25.39
North Western	0.35	9.81	0.00	10.16
South Eastern	4.19	0.11	1.94	6.24
Southern	5.71	6.39	12.49	24.59
Western	0.25	4.10	0.00	4.35
Total	**32.33**	**35.23**	**25.55**	**93.11**

Source: Department of Health and Children

2.25 The health boards had drawn down €77 million of the agreed reimbursements from the Department by 31 December 2002[11]. The Department informed me that it was able to fund the expenditure from within its existing overall capital envelope for 2002 because it had identified this requirement earlier in the year and planned accordingly. It had instructed the boards, in February 2002, not to enter into any more capital commitments without the prior written approval of the Department.

2.26 The Department informed me that remaining unapproved contractual commitments would be considered for reimbursement as the expenditure relating to them was incurred.

Views of the Department

2.27 The Department has informed me that it viewed the matter as a very serious issue. In agreeing to fund unapproved expenditure the Department specifically pointed out that funding did not imply approval. In the Department's opinion, the health boards did not comply with the established control conditions because the launch of the NDP and the pending health strategy in 2001 had raised general expectations of increased funding for much-needed infrastructural development.

2.28 A number of health boards incorrectly took the view that the indicative funding notified could be regarded as a capital allocation and engaged in capital expenditure without the Department's approval.

11 A further €20.42m was reimbursed to the health boards in 2003.

2.29 The unapproved expenditure was not incurred in accordance with procedures established by the Department. The Department gave clear instructions in various circulars and at relevant meetings in relation to capital projects and expenditure. The regime, in this regard, was no different to that which obtained in the pre-NDP period. Inclusion of proposals in health board NDP plans did not justify incurring expenditure at local level, without individual project validation and approval by the Department. The Department considered that the action of health boards, in proceeding with unapproved projects on the basis of indicative funding, was in direct contravention of several reminders from the Department that all projects were subject to prior Department approval and that the indicative funding notified was for capital planning purposes only.

2.30 The difficulties arose out of actions by some health boards which did not comply with established procedures and principles of sound management. The fact that unapproved capital expenditure was not a significant problem in all boards highlights the different approaches taken, and demonstrates that the problem was not inevitable in the circumstances that the boards faced at the time.

2.31 While initially the Department planned to introduce a devolved system, it did not give further instructions on devolution arrangements due to a number of factors that emerged subsequently. These included some lack of expertise at local level on capital procurement generally, financial pressures in the health NDP and significant construction inflation in 2000 and 2001.

2.32 No additional exchequer funding was required as a result of what occurred. However, the unapproved expenditure adversely affected the sequencing of the planned national health capital programme.

2.33 These difficulties arose at a time of transition from a situation where a relatively modest annual capital programme was the norm, to a situation where health boards, supported by the Department, were trying to ensure the effective implementation of a very much expanded capital programme under the NDP. The organisational structures in the early years of the NDP had to be improved to cope with the new situation, which required a considerable strengthening of the capital programme management and skills base. Due to the emphasis placed by Government on this initiative, and the high local expectations and significant public pressure to meet the aspirations created by the launch of the NDP, some difficulty was experienced in coping with the new arrangements.

2.34 Reimbursement was provided only to “approvable” projects that were stated to be in compliance with all necessary procurement procedures and the Department has no evidence to suggest any incorrect use of funds. The projects involved in this expenditure are appropriate health projects and no additional exchequer funding was or will be sought to deal with the issue.

2.35 The Department acknowledged that in a dynamic system like healthcare, immediate local issues become the new priority even if they are unplanned. In the case of approved projects, while unforeseen changes or improvements resulted in additional costs many of these changes would be seen as reflecting best practice or improved service delivery, and were considered approvable by the Department.

The Health Boards' Views

2.36 The health boards who responded to me both individually and collectively took the general position that all projects undertaken were necessary and were procured in accordance with established procedures of the boards. They pointed out that they had not expended funds on any project that had not been included in their NDP programmes, which were approved by the board and submitted to the Department in mid-2000.

2.37 The launch of the NDP generated very high public expectations and significant pressure to address the major gaps in health infrastructure in the context of the underfunding of facilities and equipment since the early 1980s. The urgency of overdue upgrades and replacements had been the subject of much correspondence and discussion with the Department.

2.38 Although all boards submitted NDP proposals to the Department these plans were not approved by the Department. These proposals consisted of a list of projects in each care programme together with estimated project costs at 1999 prices and cash flow profiles. These proposals were developed to match the indicative funding for each care programme and submitted to the Department with supporting documentation including a capital project request form for each project. It would have been helpful if the Department had responded to these submissions and given an indication as to what projects would be approved under the plan and the timeframe for these approvals.

2.39 In anticipation of the increased activity arising from the NDP all boards committed significant additional resources to this area and the funding of these resources is one of the elements of the unapproved capital commitments at board level.

2.40 They also pointed out that an agencies group chaired by the Department, and including representation of health boards and ERHA, which was established following the launch of the NDP to address issues such as the devolution of responsibilities to the agencies met on only four occasions and has not been convened since October 2001 despite requests by the agencies for meetings to address the problems being encountered.

2.41 The letter of notification of the NDP funding encouraged boards to plan on a multi-annual basis. At the launch of the NDP the clear impression was given that the indicative allocations would be realised as actual cash grants and one of the main reasons for issuing the indicative allocations for the future years of the NDP was to ensure that health boards had advanced the planning of projects sufficiently to enable drawdown of funding.

2.42 In the letter of February 2000 to the health boards, informing them of these indicative funding allocations, the Department retained a degree of flexibility in relation to NDP funding. However, the clear impression was given that the main reason for retaining this flexibility was to allow the Department to transfer funding from boards who were unable to spend their annual allocation on projects to those who could.

2.43 Boards were under pressure to achieve spending targets and this put pressure on health boards to deliver projects and enter into contractual commitments up to the level of indicative funding. As funding can only be drawn down on foot of project expenditure, the system placed pressure on the boards to ensure that enough projects were underway and enough expenditure had been incurred to enable them to draw down their full allocation for the year.

2.44 Given the timing of capital approvals from the Department, the length of time required to adhere to the procurement procedures and the requirement to have expenditure properly incurred in the year of approval, it was necessary to have some preliminary work done in advance of approval. These preliminary works included preparation of design and tender documents and resulted in some expenditure in advance of approval. To ensure that funds were utilised on a timely basis some boards entered into contractual commitments.

2.45 Since the launch of the NDP several new national strategies and programmes were announced. These include the new Health Strategy, Primary Care Strategy, Cardiovascular Strategy, Cancer Strategy, Bed Capacity review and Nurse Education programme. The capital developments associated with the implementation of these strategies and programmes were not included in the NDP proposals submitted in 2000. Initially it was thought that additional capital funding would be made available to fund these programmes. However, these developments had to be funded from existing capital allocations and this meant that there was less available for the boards' NDP proposals. This issue was not addressed by the Department with the health boards.

2.46 Funding arrangements on a yearly basis and in care programmes were too rigid and as a result care groups were not able to fund a major project from one year to the next as the indicative funding profile did not reflect the actual expenditure profile of the projects.

2.47 The Department had given initial or partial approval to a number of projects. The need to achieve spending targets resulted in health boards proceeding with these projects on the basis of the initial approval and on the assumption that further approvals would issue from the Department in the following years to fund their completion. The boards argue that to categorise expenditure on these projects as unapproved is unfair as it contradicts the reality of their initial approval.

2.48 The launch of the NDP coincided with a period of very high inflation in the construction industry. As was the norm the cost estimates used in the NDP proposal were the then current prices (1999). As a result when the plans were adjusted for inflation in 2001 the effect was to show that the plans were very significantly over-committed.

2.49 The number of approval stages and the time taken to receive a response to the approval requests, coupled with the demand to achieve expenditure within the year that the funding approval is issued, means that in some instances approvals are anticipated and commitments are entered into prior to the issue of the formal approval.

Revised Monitoring and Financial Control Arrangements

2.50 The Department informed me that the development of a new NDP monitoring system is now well advanced. The system will, *inter alia*, allow the Department and the boards to monitor the cost and timeliness of projects. The Department had intended to have the system running by December 2003. However, the system is currently being tested and the scheduled date is now September 2004. The final cost of the project is expected to amount to €500,000. The system has been designed to be adaptable to the health service reforms currently underway.

2.51 In regard to how the boards were able to draw down funds from the Department to finance unauthorised capital expenditure, the Accounting Officer informed me that, while the Department considered that the system of capital reimbursement had proved to be appropriate and effective for many years, it relied on co-operation from the health boards and certification at CEO level that the capital grants being drawn down related only to expenditure on approved projects. When grant

claims for the unapproved projects were eventually submitted by the health boards, the Department withheld payment pending clarification and resolution of the overall problem.

2.52 The Department advised me that unapproved commitments had not presented a problem prior to the NDP because the health boards were not willing to enter capital commitments without having the funding arranged in advance with the Department. However, those health boards which embarked on unapproved commitments during the early part of the NDP were able to finance the projects from revenue sources as, under the reimbursement system then in place, both capital and revenue requirements were included in a general cash requisition for day-to-day operations.

2.53 In March 2002, the Department introduced revised arrangements. When requisitioning cash from the Department the health board is now required to specify separately the revenue and capital expenditure involved and to identify the projects related to the capital expenditure. The Finance Unit within the Department obtains confirmation from the Department's Hospital Planning Office of the approval status of the project before releasing the cash.

Current NDP Expenditure

2.54 The health sector capital expenditure programme has been the subject of extensive revision during 2003 with the result that the original NDP budget and schedule no longer applies. The Department now allocates this funding on a project basis within each financial year. Around €1.7 billion was spent in the period 2000 – 2003. The funding provision, which altered with the provision of a revised multi-annual capital investment framework announced in the 2004 budget, is expected to be around €1.5 billion for the period 2004 – 2006. Around a further €1.2 billion will be provided in the period 2007 – 2008.

Audit Conclusions

2.55 The position in relation to the administration of the NDP Capital provision in its first two years of operation can be summarised as follows

- The Department has estimated the amount spent by health boards up to October 2002 on unauthorised capital projects and equipment was of the order of €115m.
- Planning and management systems were not sufficiently robust to secure effective control over the health capital investment programme envisaged in the NDP.
- The differing views held by the Department and the health boards about the conditions under which projects could proceed contributed to an uneven implementation of the capital programme and could have impacted adversely on the regional and sectoral investment balance which the NDP was designed to achieve.
- In the confusing circumstances which existed, some health boards advanced elements of their capital programmes without reference to the Department.
- The Department was put in a position where it had no real option but to fund most, if not all, unauthorised capital commitments by health boards.

Response of the Accounting Officer

2.56 In regard to the statement by the boards that it would have been helpful if the Department had responded to submissions and given an indication as to what projects would be approved under the plan and the timeframe for these approvals, the Accounting Officer pointed out that there

were, in fact, a total of 13 meetings held between the Department and the boards in the March/April 2000 period, where detailed discussions took place on the boards' capital investment plans.

2.57 The Accounting Officer also stated that the Department had issued detailed and clear procedures to boards on numerous occasions. Nothing could be clearer than the explicit instruction in those letters to health boards to operate the normal procedures on approval. Contractual commitments had been entered into by health boards without the express approval of the Department.

3. Patients Private Property Accounts

3.1 Patients Private Property refers to money and personal possessions (for example jewellery) that patients have with them on admission to hospital and which are lodged with the hospital authorities for safe-keeping during their stay. In the case of long-stay patients, the property in question also includes regular pension payments and financial records such as pension books and bankbooks. The property is administered by the hospitals as a service to patients, particularly those patients who are not in a position to administer the property themselves, or are unable to appoint a family member or other person to act on their behalf.

3.2 I have commented previously on the management of patients' private property (PPP) in my Report on General Matters arising out of Audit of 1995 Accounts in the health sector. Following this, the health boards and the Department began to assess their obligations and options with regard to PPP. The Eastern Health Board sought legal advice on the matter on behalf of the other health boards. The Department consulted the Chief State Solicitor's Office on the treatment of property belonging to patients without next-of-kin who die intestate while in hospital care. A Working Group of representatives from the health boards was established to review the management of PPP. The Working Group reported its findings and recommendations in May 1999 and referred them to the health boards for implementation.

3.3 The total amount of these funds held by health boards at 31 December 1995 was €21.3 million. By 31 December 2001, the total value of patients' property held by the health boards was €17.4 million. The decrease in value appears to reflect the diminishing number of dormant PPP accounts, the impact of the transfer of dormant accounts to the Chief State Solicitor's Office (CSSO) and the retention of interest by the health boards in lieu of charges.

3.4 The value of PPP Accounts held at 31 December 2001, as reported by the health boards, is set out in Figure 3.1 below.

Figure 3.1 Value of PPP Accounts Administered by Health Boards 31 December 2001

Health Board	Value of PPP Accounts €'000
East Coast Area Health Board	549
Northern Area Health Board	1,628
South Western Area Health Board	1,531
Midland Health Board	1,038
Mid Western Health Board	1,665
North Eastern Health Board	1,821
North Western Health Board	935
South Eastern Health Board	1,845
Southern Health Board	2,959
Western Health Board	3,417
Total	**17,388**

Source: Health Boards

3.5 I have returned again to the issue in order to assess the progress made in recent years on the management of PPP by the health boards and on the implementation of the recommendations of the Working Group. I surveyed the health boards for this purpose and also requested the views of the Department. My report is based on the responses received and covers

- the current system in place generally for managing patients' private property in the health boards
- the charges levied by hospitals and care institutions for administering patients private property and
- the treatment of property belonging to deceased patients.

3.6 My report does not address the effectiveness of procedures for the efficient and lawful release of property to next-of-kin, but this matter should be addressed by the Department, in conjunction with the health boards.

Managing Patients Private Property

Patients' Property Procedures

3.7 The health boards were requested to provide information on the arrangements currently in place to ensure that all funds held on behalf of patients are accounted for and that all non-financial property is safely recorded, labelled, stored and insured against loss or damage. The responses received from health boards indicate that most boards apply the same general approach in accounting for patients' property surrendered for safekeeping. The general practice is that, on admission, a detailed list is made of all property in the possession of the patient including money and personal possessions. The list is completed in triplicate and signed by the patient or by an accompanying relative or friend and by the nurse in charge. The original form is given to the patient, a copy is sent with the property to the Hospital Administrator and a further copy is kept in the ward. A receipt for the cash and/or goods is issued to the patient by the Administrator who enters the property into the hospital's patient private property register and under the individual patient's PPP account - an account which is opened for the purpose of recording and controlling the receipts, withdrawals and balance of funds of individual patients.

3.8 Once registered, personal possessions are placed in a locked safe in a sealed and labelled envelope bearing the patient's name and property register number. Money surrendered for safekeeping is receipted and lodged in a specific bank account for patients' funds operated by the hospital/care institution. Patients in long-stay care also have regular pension receipts lodged to their PPP Accounts. The funds and the bank account are managed by an officer authorised for that purpose. Some health boards report that they also operate a control account showing the total funds lodged and disbursed and the balance for all patients. The control account is balanced each month and reconciled with the total of the balances in the PPP accounts and the total in the patient's property bank account.

3.9 Annual financial statements on the funds held in PPP Accounts are prepared by the hospitals. The financial statements relating to patients' private property are separate to and independent of hospital and health board accounts and are examined by independent auditors.

3.10 Most of the health boards confirm that the hospital's insurance extends to the patients' property surrendered for safekeeping. However, three health boards did not address this issue in

their responses - the North Eastern Health Board, the North Western Health Board and the Mid Western Health Board.

Accounting System

3.11 The Working Group reviewed the accounting systems for patients' property which operate in health boards and found that, although some computerisation had been introduced over time, different systems were in use. The Group considered that it was timely to review these systems to ensure that they met the requirements of modern day accountability and of recent legislative changes. The Working Group also recommended that a single computerised system and a common set of standard procedures be put in place as soon as possible.

3.12 I asked the health boards whether they had reviewed their administrative systems and software and the outcome of the review. Most boards had carried out a review but not that envisaged by the Working Group. The reviews were carried out to ensure the accounting and computer systems were both Year 2000 and Euro compliant. In general, health boards appear to be satisfied that their present accounting systems, coupled with the standing financial instructions and the assurance from internal and external audit, are effective in managing patients' funds.

3.13 The response from most boards did not address the Working Group's recommendation for a single computerised system and for a common set of procedures for managing patients' private property. However, the boards stated that they were satisfied with the current systems in operation. Some boards operate a combination of computerised and manual accounts, depending on the size of the institution in question. The Mid Western, the Southern and the South Eastern Health Boards report that they use common, computerised accounting systems at all locations. In contrast, the North Western Health Board states that it is not feasible to introduce a common system across the Board. None of the health boards addressed the issue of common accounting and computerised systems at national level, therefore it is assumed that this issue has not been progressed.

Administration Charges

3.14 Hospitals and institutions incur costs in the process of the administration of PPP accounts. These include the cost of time spent by nursing staff with patients on the issue, the cost of administrative staff who manage the accounts and bank account fees. The practice in some health boards was to recover administration costs by levying a charge on PPP Accounts. The Working Group received legal advice that the relationship between the hospital and the patient in such circumstances is one of bailment[12]. The Group concluded that the practice of levying an administration charge on PPP Accounts was inconsistent with a bailment relationship and recommended that it should cease and that, instead, the administration costs incurred should be met from a health board's general administration costs.

3.15 The financial property surrendered by patients for safekeeping is lodged to a bank account in the hospital's name. Following legal advice on the bailment relationship, the Working Group recommended that the interest earned from the funds so lodged should be retained by the institution and not be credited to the individual patient. The recommendation was justified on the basis that the bailment relationship implied a duty only with regard to the original property lodged.

12 Bailment is the transfer of possession of property by the bailor (in this case, the patient) to another person (the bailee, in this case the hospital) for some temporary purpose (safeguarding) after which the property is either returned to the bailor or otherwise disposed of in accordance with the contract of bailment.

The Working Group recommended that, while the patient retains the principal, the interest accumulated should be transferred to the Board's own account at regular intervals. The Working Group's recommendations had the effect of advising that, rather than charge administration costs, the health boards should retain the income earned from the investment of patients' financial property.

3.16 Most health boards have adopted this approach and now transfer income earned on PPP investments to their own accounts. Figure 3.2 sets out the administration charges levied by the health boards on PPP Accounts and PPP fund investment income taken to account by the health boards in the period 1999 – 2001. In most cases, the administration charges are replaced by the interest earned during this time. However, some boards continue with administration charges following legal advice to that effect.

Figure 3.2 Administration Charges and PPP Investment Income Taken to Account 1999 – 2001

	Administration Charges levied on PPP Accounts			Interest taken to Account from PPP funds invested			Total cost recovered by Board
Health Boards	**1999 €'000**	**2000 €'000**	**2001 €'000**	**1999 €'000**	**2000 €'000**	**2001 €'000**	**€'000**
Eastern Regional Area Health Boards[a]	639	—	—	—	13	395	1,047
Midland Health Board	—	—	—	106	57	50	213
North Eastern Health Board	191	127	—	—	—	127	445
North Western Health Board[b]	—	—	—	—	—	1,016	1,016
Western Health Board	—	—	—	240	155	154	549
Mid Western Health Board	228	239	241	—	—	—	708
Southern Health Board	—	—	—	73	76	76	225
South Eastern Health Board[c]	39	28	44	—	—	—	111
Total	**1,097**	**394**	**285**	**419**	**301**	**1,818**	**4,314**

Source: Health Boards
Notes
a East Coast Area Health Board, Northern Area Health Board and South Western Area Health Board
b Accumulated interest taken to account in 2001
c Administration charges equivalent to investment income

3.17 Most of the health boards have gradually moved to the recoupment of the cost of administering patients' property from interest earned in PPP investments. In the period 1999 to 2001, the health boards took to account about €2.5 million in PPP investment interest and a further €1.8 million in direct administration charges.

3.18 Not all health boards retain the income earned from investing PPP funds, or cover administration costs in this manner. The Mid Western Health Board considers that the relationship between the Board and patients of diminished capacity is that of trustee rather than bailee. As most of its patients have diminished capacity the Board continues to apply administrative charges. The

interest earned on PPP funds invested (€332,966 over the period 1999 to 2001) is not taken to account by the Board.

3.19 The South Eastern Health Board continues to treat PPP fund investment income as the patient's income. According to legal advice received by the Board in the 1980s the relationship between the Board and the patient is one of trustee and income from PPP investments belongs to the patient. The Board was also advised that it can only raise an administration charge with the agreement of the patient. The Board takes the position that it is responsible for administering the patient's property as part of its institutional service. The Board considers that the investment income accruing to the patient comes within the scope of the Health (Charge for In-Patient Services) Regulations, 1976 and the Board raises a charge for services under these regulations equivalent to the investment income.

3.20 In conclusion, there seem to be a number of approaches by health boards in dealing with investment income and administration charges and there is conflicting legal advice on the issue.

- On the basis of legal advice, the Working Group recommended that, as bailees, the health boards were obliged only to safeguard the principal sum lodged with them by the patient and were entitled to retain any income earned on the investment of this sum.
- The South Eastern Health Board acts on the basis of earlier legal advice to the effect that it is a trustee in such cases and has neither the right to retain interest earned on PPP funds invested nor to levy a charge for the PPP service without the agreement of the patient.
- The Mid Western Health Board takes a similar approach but charges an administration fee for the service.

3.21 The existence of conflicting legal advice places a question over the policy of retaining interest and charging administration costs without an agreement with the patient. The legal position should be resolved as soon as possible and all the health boards should be placed on a common footing with regard to charges and investment income.

Investment

3.22 The Working Group recommended that health boards should increase their investment yield by jointly investing the funds held in PPP Accounts. It further recommended that one health board should be appointed to negotiate with finance agencies on behalf of all Boards with a view to maximising the return on the joint investment.

3.23 The Working Group's recommendation on joint investment has not been adopted by the health boards. The boards still invest PPP funds independently of each other. In most, either the Director of Finance or the Financial Accountant is responsible for managing the investments. Figure 3.3 sets out the investment products used by the boards.

3.24 It is not practicable for all institutions to engage in proactive management of their investment, either because of the relatively small amount available in some cases or the need to maintain liquidity of the funds. One board reported that it had examined the case for joint investment and found it to be impractical. Nevertheless, in view of the variation in return on their investment and the overall size of the funds available for investment among all boards and hospitals (€17.7 million in 2001) consideration should be given to the Working Group's recommendation. Additional options should be considered, such as investing jointly a portion of

the funds, or negotiating centrally a favourable investment product suitable for joint or individual management by the boards and hospitals.

Figure 3.3 PPP Funds Invested by the Health Boards 2001

Health Board	Investment Product	Average Return for 2001
Eastern Regional Area Health Boards[a]	Various Treasury bonds, Promissory Notes and call deposit accounts	5.9%
Midland Health Board	Deposit Account	5.2%
Mid Western Health Board	Three monthly investment deposits	4.8%
North Eastern Health Board	ICC Investment Account	4.9%
North Western Health Board	Short Term Government Bonds	5.5%
South Eastern Health Board	Gilt-edged interest/dividend yielding investments	4.6%
Southern Health Board	Three monthly fixed deposit accounts	4.8%
Western Health Board	ICC Term Deposits	5.6%

Source: Health Boards
Note a Including the Eastern Regional Health Authority, the East Coast Area Health Board, the South West Area Health Board and the Northern Area Health Board

Patients with Diminished Capacity

3.25 In relation to the private property of patients with diminished capacity, the Working Group concluded that these patients, by the nature of their illness, might be unable to make decisions about their finances or their PPP Accounts. In such cases, the Board had an increased duty of care which might change the bailment relationship. The Working Group recommended that an agreed process be established for such patients.

3.26 The responses from the health boards indicate that the Working Group's recommendation on the establishment of an agreed process for administering the property of patients with diminished capacity has not been implemented. However, the Western Health Board and the South Eastern Health Board have certain procedures for the administration of the property of these patients.

3.27 In the Western Health Board, when a patient's property is taken into safekeeping the list is signed, if possible, by a friend or relative. A medical officer, matron, head nurse, ward sister or other specific staff member authorises withdrawals for the patient's use or benefit and completes a withdrawal form accordingly. Where practical, the patient signs the form. A limit may be placed on cheques drawn, above which the authority of the general or regional manager or other authorised officer may be required.

3.28 In the South Eastern Health Board, if patients are unable, by reason of diminished capacity, to make decisions on their finances, these decisions will be made on their behalf initially and on a temporary basis, by senior nursing staff. If the situation is likely to be ongoing, a decision is made by hospital management, following medical and nursing advice, to avail of the Wards of Court process.

Property of Deceased Patients

Releasing Property to Next-of-kin

3.29 Where a patient dies while under the care of the health boards, the boards trace the next-of-kin and release the property to them as inheritors of the estate. The Working Group recommended that the health boards adopt a common procedure for tracing next-of-kin and for releasing property, but the survey results indicate that no progress has been made in this regard.

3.30 However, most boards have established their own procedures for releasing property to next-of-kin. These include requirements for evidence of legal authority to receive the property and formal receipt and indemnity procedures to safeguard against subsequent claims by other people.

3.31 There are broad similarities between the procedures of different health boards. Most contact the next-of-kin listed in the admission records and arrange for release to them of the patient's personal possessions and funds after deducting funeral and other expenses. With the exception of the Western Health Board, which stated that it applied to the Community Welfare Officer for assistance in such cases, most health boards did not indicate what procedures, if any, are in place for cases where registered next-of-kin could not be traced immediately.

Unclaimed Property

3.32 In 1998, the CSSO advised the Department that the State is the ultimate successor, under the Succession Act, if a person dies intestate and without known claimants. This means that, where the health board is unable to trace a person who is legally entitled to take possession of the property of the deceased patient, the property must be transferred to the State. The State is also entitled to any interest accruing from the date of death.

3.33 Consequent on this advice, the Department instructed the health boards to follow the procedure used by private sector financial institutions for estates of less than €10,000 in value. This procedure allows the institutions to transfer estates of small value to the Escheated Estates Fund[13] on the indemnity of the CSSO, thus avoiding the expense of obtaining Letters of Administration for these estates. The Department also requested the health boards to identify all unclaimed intestate PPP Accounts held by them and inform the CSSO accordingly and to establish regular procedures for this purpose in future cases. The Working Group reported that all health boards had submitted to the CSSO, in so far as their records allowed, details of unclaimed intestate estates held by them up to 31 December 1996.

3.34 Figure 3.4 outlines the position regarding unclaimed and intestate patients' property transferred to the CSSO, including the date to which dormant funds have been identified and transferred to the CSSO following receipt of the Department's instructions, and the amount of money involved.

13 Under the Succession Act, unclaimed intestate estates are transferred to the Escheated Estates Fund and this Fund is managed by the CSSO.

Figure 3.4 Transfer of Unclaimed Intestate Patients Private Property and Interest to the CSSO

Health Boards	Date to which transfers effected	Total Transferred (€'000)
Eastern Regional Area Health Boards	December 2000	1,386
Midland Health Board	December 2001	343
Mid Western Health Board	September 2000	46
North Eastern Health Board	December 1998	184
North Western Health Board	December 1996	433
South Eastern Health Board	December 1999	524
Southern Health Board	December 2000	340
Western Health Board	December 1997	524
Total		**3,780**

Source: Health Boards

3.35 In the Southern Health Board the number of patients in larger institutions is falling and the instances of patients without next-of-kin has fallen dramatically. This is likely to be the case in most health board institutions and suggests that the bulk of the funds transferred to the CSSO to date represent a backlog of old cases. The Western Health Board states that it has just €9,080 ready for transfer for the period 1998 to 2000, indicating that the amount of funds available for transfer to the CSSO by all boards is likely to be much reduced in future.

3.36 While all the health boards have implemented the Department's instructions on transferring dormant funds, only some boards appear to have implemented its instructions on adopting regular procedures for notifying the CSSO of unclaimed intestate property and none of the health boards calculate and transfer to the CSSO the interest earned on the dormant account after the patient's death.

3.37 The Northern Area Health Board has pointed out that any transfer of interest would imply a change to the bailment relationship and legal clarification was needed on this point. It stressed that the amount of money involved, particularly with the transfers of the principal to the CSSO occurring periodically, is not in any way material.

Personal Possessions

3.38 With regard to personal possessions of deceased patients (such as jewellery, watches, etc.), the Working Group advised that uniform procedures should be followed by the health boards to ensure that the possessions were passed to the legal representative of the deceased. The Working Group further recommended that, where items were unclaimed for more than six years, they should be disposed of by health boards and any monies accruing should be retained by the Board to fund overheads incurred in storage, security, insurance and administration.

3.39 With the exception of the Western Health Board, the boards have not implemented the Working Group's recommendation for disposing of unclaimed personal possessions. Most of the health boards give the patient's personal possessions to the next-of-kin. Otherwise the possessions are held until claimed. The boards state that the value of unclaimed possessions is minimal. The

Southern Health Board informed me that, in past years the cost of disposing of unclaimed possessions would have exceeded their value and they were donated to charity.

Future Proposals

3.40 The chief executives of the health boards are considering the possibility of implementing a standard national approach to the management of patient's private property to link in with the creation of the Health Services Executive.

Audit Conclusions

3.41 The position in regard to the implementation of the Report of the Working Group which examined the management of patients private property can be summarised as follows

- No progress has been made in introducing a standard single computerised recording system across boards.
- Accepting the view of the Working Group that they held patients funds under a contract of bailment, boards in six of the eight regions had moved by 2001 to retaining interest earned on these funds rather than levying administration charges.
- Two boards continue to treat investment income as the property of the patient, considering their relationship to be that of a trustee.
- No progress has been made in moving towards joint investment of funds.
- An agreed process for the administration of property of persons with diminished capacity has not yet been put in place.

3.42 At the direction of the Department, all boards are remitting funds from dormant accounts to the CSSO.

Response of the Accounting Officer

3.43 The Accounting Officer noted that the current system operated by health boards for the safeguarding of patients' private property is operating quite satisfactorily and that there is no evidence of any significant shortfalls in the administration of the scheme.

3.44 The fact that the implementation of a common accounting and computerised system at national level for managing patients' accounts did not progress may well be attributable to the difficulties that might be experienced by local services in accessing a patient's funds. Given the relatively small amounts of money involved, it would be the view of the Department that the use of well managed transparent accounting systems at local level is less cumbersome and more advantageous to both the patients and the fund managers and that this outweighs the marginal advantage that might be attributable to a centralised system.

3.45 In relation to the recommendation that health boards should increase their investment income by jointly investing the funds held in PPP accounts he pointed out that, in respect of 2001, significant investment yields were secured by health boards. While there may be some merit in the suggestion that combining the investment might produce a higher yield, it could be argued that the cost of establishing, managing and operating such a national system would offset any increase in investment yields.

3.46 While the current system of the management by health boards of patients' private property accounts is operating satisfactorily, he acknowledged that there remain differences in the methodology employed by some health boards. Given the conflicting advice received by the health boards, the Department accepts the wisdom of the need for clarity in relation to the legal aspects of this issue, and has advised the boards to seek legal advice on a collective basis.

4. Controlling Employee Numbers in the Health Service

4.1 I have from 1995 onwards, in a number of reports on accounts of health boards, referred to the lack of reconciliation between numbers of staff recorded on personnel records and the numbers included on payrolls. In addition, my report on the accounts of the Eastern Health Board for 1998 drew attention to the fact that the Board had exceeded its sanctioned establishment.

Control of Staff Numbers

4.2 In 2001, the Department of Health and Children introduced new systems of devolved control over staff numbers employed in the health service. The new system delegated authority to the health boards and agencies to fill non-consultant posts on the basis of the resource needs indicated by their service plans. It was intended to encourage agencies to plan and manage their staffing requirements on a more autonomous basis, while having regard to the availability of resources.

4.3 As part of their service planning for that year, the health boards and agencies were asked to specify the number, grade and category of whole-time equivalent (WTE) staff that they proposed to employ over the coming year. The service plan would specify planned employment on a month-by-month basis.

4.4 The devolved system of employment control operated until the end of 2002, at which time the Government had decided to cap the numbers employed in the public sector as a whole, and a more centralised system was re-introduced. An analysis of the end-2001 health service personnel census showed that health boards and agencies were employing the whole-time equivalent of 3,800 staff in excess of the approved complement for that year[14]. Agency staff contracted under arrangements with employment agencies are not reported in the census and are not recorded as part of the approved health service workforce.

4.5 The Accounting Officer informed me that the employment of excess staff arose in the following context

- significant increases in funded activity levels
- the lagged effect of new services becoming operational and uncertainty regarding their full employment impact
- changing work patterns led to higher staff replacement ratios
- limitations in the existing methodology for determining the employment ceiling and, in particular, in forecasting the full employment consequences of new service investments
- a very substantial increase in health expenditure where the rate of investment substantially exceeded the rate of increase in human resources.

4.6 He acknowledged that monitoring was hampered by deficiencies in management information on human resources which had led to an underestimation in the number of posts needed to support approved activity levels.

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14 The census extended to Health Boards, Voluntary Hospitals and core intellectual disability services.

4.7 The situation in the health boards and agencies was regularised by increasing the approved national employment ceiling to 96,000 WTE personnel (excluding home helps). This approach was adopted because the Department was satisfied that additional staffing was needed to allow the delivery of approved services.

Resource Implications of Excess Staff

4.8 With regard to the impact of the excess staff on the capacity of health boards to stay within the financial and staff resource allocations set out in their Letters of Determination, the Accounting Officer informed me that

- He was satisfied that the unapproved staff were not a significant cause of financial pressures for the health service and were accommodated within approved funding levels. He was also satisfied that they would not give rise to structural or underlying financial pressures in the future.
- The Department had not sought or been offered additional financial resources from the Department of Finance in relation to the increased employment ceiling.
- The chief executive officers of the health boards took the position that the actual level of employment in each region was consistent with the number of staff required to deliver approved and funded service plan commitments.

4.9 The Accounting Officer informed me also that the decision to resolve the problem by increasing the approved employment ceiling was borne out subsequently when the health boards, with the exception of the ERHA, achieved a break-even position in their financial outturns for 2001 and 2002. Financial pressures, such as those experienced by the ERHA, arose from factors unrelated to approved employment levels. These factors reflect the impact of non-pay items such as medical inflation, high-tech drugs, insurance and legal fees and demand-led schemes such as the GMS, the Drugs Payment Scheme and the Long-Term Illness Scheme.

4.10 However, the Accounting Officer also informed me that a recent review of the service plan process highlighted instances where a number of boards had staffing requirements that may not have been met when funding for additional services was released during 2002. These shortfalls are continuing to give rise to difficulties in remaining under the approved employment ceilings. In June 2003, there was an excess of 607 WTE staff in the wider health service. The Accounting Officer identified the following as contributory factors.

- The health boards took over certain responsibilities previously carried out by private agencies and this resulted in the transfer of 152 staff to the boards. These agencies were not included previously under the health service employment ceiling and their staff were not included in earlier census counts.
- The number of nursing personnel increased by 360 WTE between December 2002 and June 2003. A significant proportion of this increase is attributable to the direct recruitment of nurses to substitute for the more expensive agency nurses.
- The staff numbers at June 2003 are affected by seasonal factors that contribute to a mid-year peak in the profile of service provision in the health sector.

4.11 The Accounting Officer informed me that the Department is continuing to work closely with a number of health boards to ensure adherence to the regional and national employment ceilings. Although the employment ceiling is acknowledged to be a crude tool that does not reflect

the complexity of resource management decisions, the Department will continue to use it as a control mechanism pending the availability of more accurate data on staff numbers.

The Accurate Determination of Staffing Requirements

4.12 With regard to the weaknesses in the methodology for determining the correct staffing needs of health agencies, the Department has recently agreed with the Department of Finance on the terms of reference for a Working Group on Employment Methodology. The terms of reference for the Working Group are as follows.

- To review the existing methodology for enumerating staffing levels and to review the process for establishing the authorised employment ceiling and approved employment increases in the health services on the basis of the recommendations of the Report of the Commission on Financial Management and Control.
- To recommend what methodology should be applied having regard, in particular, to issues of definition and information, the respective needs of the employing authorities, the Departments and the Central Statistics Office and the linkages between approved employment levels, funded employment levels and the pay bill.
- To recommend how existing and future policy on staffing levels in the health services should be monitored and controlled, both in the short term and in the context of revised structures for the health service, having regard to the roles of the Department, the Department of Finance and the employing authorities.

4.13 An interim report from the Working Group was completed in December 2003. The Accounting Officer informed me that this interim report had summarised the findings to date and made recommendations for the next steps to be taken in reviewing the methodology to enumerate staffing levels for determining the employment ceiling for the health service. Discussions are ongoing with the Department of Finance to take account of issues raised in the interim report.

Monitoring and Reporting Systems

4.14 Employment levels in the health services are reported through the Health Service Personnel Census (the census) carried out by each health board and agency.

4.15 In addition, the Department monitors employment in the health boards and agencies on a monthly basis through the Integrated Management Returns (IMRs). The IMRs confirm adherence to the approved employment ceilings and provide a commentary on any variance between planned and actual employment levels. However, the human resource data returned under the IMR system is less comprehensive than, and is presented in a different format to, the data supplied in the census.

4.16 Heretofore, the personnel census was a stand-alone, annual data-gathering exercise that operated separately to the IMR system. Under this system the end-year employment level information was not available until the middle of the following year. Consequently, the Department decided that the census should be conducted on a quarterly basis from mid-2003 to provide a more timely measure of employment trends and to enable the Department to monitor compliance with the approved employment ceilings. Quarterly census data is now available within three months of the end of the relevant quarter. The Department informed me that reporting time-frames continue to improve with a high proportion of agencies submitting returns within the

required period. However, it should be noted that comprehensive final quarterly figures can only be prepared by the Department when returns are received from all agencies.

4.17 It is intended that these census reports will, in due course, be subsumed under the IMR system. In the meantime, as part of its remit the Working Group will examine the revisions required in the IMR data supplied to the Department.

4.18 In addition, the Department is addressing the ICT weaknesses that constrain the effective and timely compilation of reports, principally through the Personnel Payroll and Related Systems (PPARS) project.

Views of the Health Boards

4.19 The health boards noted some dysfunctional effects of the adopting of what they considered a crude employment control limit in the health sector, arising out of their experience during 2003.

- It is possible for a board to achieve financial breakeven within the financial limits determined by the Minister in any year but still exceed its employment ceiling. In this context the employment ceiling can be an undue constraint on operational flexibility.
- Adoption of a strict employment ceiling can encourage boards and other health agencies to contract personnel. An example of this would be in relation to nursing where the application of a ceiling may have the effect of increasing the numbers of agency nurses in use within the health system.
- Proposals that might yield value for money can be hindered by the application of a strict employment control ceiling. Human resources may sometimes be managed more effectively by restricting overtime rather than job numbers. The application of a strict ceiling prevents this kind of initiative.
- The ceiling was set at a point in time and does not reflect the establishment but rather the number employed at the end of December 2002. In particular services there were instances of the establishment number being greater than the number employed and no account has been taken of this since setting the ceilings.
- While health boards had received some development resource in 2004 to target key services, ceiling adjustments have not been made to enable recruitment of staff to undertake these service developments.

Views of the Department

4.20 The Accounting Officer pointed out that the Department had set regional employment ceilings, in December 2002, for each health board and notified the CEOs accordingly. The CEO of each health board is responsible for managing the workforce, including the appropriate staffing mix and the precise grades of staff employed within the boards. The Letter of Determination (which outlines the board's annual allocation) issued to each CEO the following January stipulated that no posts above the authorised ceiling could be filled and the employment requirements for specific services should be met through the management of each board's approved staffing complement.

4.21 The Department set out the following revised procedures for controlling and monitoring employment in the health service from 2003 onward.

- Each agency, submitting a service plan to the Department, must include a statement that the activity levels indicated in the plan can be delivered within (or below) its approved employment ceiling.
- Where an additional staffing requirement may arise, agencies must indicate to the Department how this requirement is to be met by a re-deployment of staff from within its approved employment ceiling on a cost-neutral basis.
- Subject to existing industrial relations agreements, grade drift is to be tightly controlled.
- Each agency must identify to the Department the arrangements it has put in place locally to ensure that the above requirements are adhered to throughout the year, including accountability arrangements at management level.

4.22 The Department also instructed the health boards to institute a senior management framework for controlling the employment levels within each health board and meeting accountability requirements.

4.23 A designated unit of the Department, headed by an Assistant Principal Officer, is assigned responsibility under the Department's Business Plan for monitoring and ensuring compliance with employment control in the health service.

4.24 The Accounting Officer informed me that the Department works closely with each of the health boards, formally and informally, to ensure adherence to the regional employment ceilings.

Audit Conclusions

4.25 Attempts to control staff numbers in the health sector have in the past been hampered by

- a lack of reliable information on the numbers employed
- time lags in collecting and collating employment data
- approval of new services without the necessary authorisation for additional staff.

4.26 The decision to devolve responsibility for staff numbers to the health boards and agencies in 2001 when these shortcomings had not been addressed compounded the problem.

4.27 Contract and agency staff should be reckoned when applying staff numbers limits.

4.28 Staff requirements should be determined, where possible, by reference to national benchmarks.

Response of the Accounting Officer

4.29 The Accounting Officer could not accept that controls over staff numbers had been ineffective owing to a lack of reliable information on the numbers employed nor that employment control information was unreliable.

4.30 However, it was acknowledged that lack of investment in information systems has resulted in weaknesses in the Department's and the health boards' ability to control and monitor numbers employed. He pointed out that this resulted from priority in capital investment traditionally being given to new service developments rather than to information systems. This lack of investment is currently being addressed with the implementation of a new HR system at an initial cost of €130

million (for implementation in the health boards and St James's Hospital). Rolling out the system to the remainder of the health sector will result in further estimated costs of approximately €100 million, which shows a very significant commitment on behalf of the health services towards addressing this information deficit.

5 Billing for Services to Private Hospitals

5.1 Public hospitals carry out tests and procedures on behalf of the patients of other hospitals and institutions, including private medical institutions. In April 1997[15] I reported that Beaumont Hospital did not invoice the adjacent private clinic, Beaumont Private Clinic (BPC) for tests carried out on its patients and that Beaumont had not changed its charge rates for laboratory services since 1991. Assurances were given at that time that BPC would be invoiced and that charge rates would be adjusted to reflect the actual costs of services.

5.2 During the course of an audit by my staff at Beaumont Hospital it came to attention that the Hospital was still not invoicing BPC. The audit estimated that Beaumont Hospital had forgone some €2.7 million in revenue from BPC between January 1998 and December 2002[16]. It also emerged that, while the rate charged to other external agencies for carrying out tests was increased in May 2000 and again in March 2002, in both instances the increase was calculated by adding 10% to the existing rate and there is no indication that charge rates are based on the actual costs of carrying out the tests or that they correspond with current commercial test rates.

Response from Beaumont Hospital

5.3 In response to my enquiries Beaumont Hospital informed me that

- it provides a range of pathology services and a limited range of radiological services to BPC. The workload from BPC constitutes just over 2% of the total pathology activity for the hospital and less than 0.25% of its total radiological activity.
- Applying charge rates based on the hospital's expenditure on pathology services, Beaumont Hospital estimates that the total cost applicable to BPC in the period January 2003 to mid-September 2003 amounted to €288,000. This rate includes direct pay and non-pay costs only and does not include overheads of services, equipment or non-pathology staffing.
- Beaumont Hospital commenced invoicing BPC at full commercial rates, with effect from 1 May 2003. The invoices have been issued on a monthly basis since then and are the subject of ongoing correspondence with BPC. No payment has yet been received.
- Beaumont Hospital has been issuing invoices over a number of years for tests carried out by the hospital on behalf of other external agencies. The rates applied to other public agencies are based on 60% of the commercial rate. However, payment has only been received for some invoices, that is, those issued by agreement.
- Since April 2003, Beaumont has been invoicing all agencies to which it is supplies pathology services, whether an agreement is in place or not.
- Previous analysis in Beaumont Hospital indicated that the commercial rates charged were not inconsistent with the full economic cost of providing such services.

15 Report on General Matters Arising out of Audit of 1995 Accounts in the Health Sector.

16 This is based on 117,014 unbilled tests in that period at an average rate of €23.37 per test.

5.4 On the delay in implementing charges, Beaumont Hospital explained that patients are treated by BPC on an outpatient basis only. BPC is not designed to provide inpatient treatment. Accordingly, the services provided by Beaumont Hospital to BPC are on behalf of private outpatients. Beaumont Hospital reviewed the situation on a number of occasions in recent years. However, as the Department's policy stipulates that public hospitals are not entitled to charge for any outpatient services, irrespective of the insurance status of the patient, the hospital concluded that sufficient doubt existed as to the entitlement of patients from BPC to free services. In 2002, Beaumont Hospital reviewed the matter again and, in 2003, commenced invoicing BPC and all other external agencies for services provided.

Response from the Department of Health and Children

5.5 As the health boards informed me that issues relating to inpatient and outpatient billing are system-wide, I requested the Department to provide information and any relevant general observations on the following issues

- the Department's policy on the provision of services by public hospitals to private medical institutions and their patients
- the policy of the Department in charging for these services
- the extent of recourse by private medical institutions to the services provided by the public hospitals and the impact this recourse has on services to public patients
- the action taken or proposed to monitor compliance with Department policies on the provision of and charging for services.

5.6 In response to my enquiries, the Department informed me that a patient who is referred from a private hospital for outpatient services in a public hospital is automatically deemed to be a private patient of the consultant concerned. In these circumstances, private outpatients are liable to pay consultants' fees to the public hospital consultant who provides the outpatient services.[17]

5.7 The Department emphasised that it is very much in the hospital's own interest to effectively manage income from charges in accordance with Department policy and the legal framework within which the hospital operates. The income from charges is an integral and important part of the funds available to hospitals. With regard to the level of charges set for services carried out for private institutions, it is the policy of the Department that public agencies should seek to recover the full cost of these services.

5.8 Notwithstanding the overall policy, the Department's position on charging for services may need clarification on the following points

- The Department's policy does not provide specific guidance on charging for public hospital services provided to outpatients referred by BPC. However, while the Department's policy does not provide guidance for Beaumont Hospital on charges for public hospital services provided to outpatients referred by BPC, the Department informs me that the hospital was advised, by way of letter to the CEO, that charging private facilities for the use of public services is permitted. The hospital may not directly charge the patient but the private facility is subject to a levy.

17 Section 3 (2) of Health Services (Outpatient) Regulations, 1991 (Statutory Instrument No. 136 of 1991)

- The Department's policy provides some guidance on charging private patients personally attending a public outpatient department, but only in relation to consultants fees. The private patient is liable to pay fees to consultants involved in a consultation at Beaumont Hospital's outpatient department. These fees are retained by the consultant. However, public hospitals bear certain costs arising out of the provision of outpatient services and the Department policy gives no guidance on their recovery. A statutory charge for outpatient department visits and laboratory activity introduced in 1987 was subsequently abolished in 1994 on the grounds, the Department informs me, that it had inherent problems of anomalies, inequities, interpretation difficulties and potential barriers to necessary treatment. Notwithstanding that, the Health Strategy recognises the need to ensure that charging and eligibility systems should ensure that appropriate care is delivered in the appropriate setting and accordingly, sets down a commitment for an examination of the levels of, and collection arrangement for, charges.

5.9 With regard to my query on the extent of recourse by private medical institutions to the services provided by public hospitals and the impact this has on services to public patients, the Department informs me that it has undertaken a system-wide information gathering exercise in 2003 to establish the situation. This found that the overall volume is low and does not pose capacity problems for the public hospitals. It has been estimated that referrals from private hospitals to public hospitals represents about 2-3% of total laboratory activity. Such referrals do not impact on either the laboratory capacity or access to such capacity for public patients.

5.10 On the question of monitoring the implementation of its charging policy, the Department states that, while it does not have an executive function in delivering health services, it does monitor the health boards and other statutory and voluntary agencies through the service planning process.

Audit Conclusions

5.11 The overall position in regard to charging for laboratory type services was as follows

- The failure to clarify policy on charging private patients of consultants in private hospitals for public health outpatients services has led to a failure to collect revenue in Beaumont Hospital and possibly other hospitals.
- The system-wide nature of the problem suggests an urgent need for clarification of eligibility and entitlements in this area.

Response of the Accounting Officer

5.12 The Accounting Officer informed me that the Department is currently reviewing the legislation with a view to clarifying and updating provisions governing eligibility and entitlement to services including the area of charging.

5.13 He noted that the position in relation to public hospitals charging private hospitals for services provided for in-patients of private hospitals is clear. The private hospital, not the patient, can be charged for services provided in these cases. The situation in relation to out-patients is less clear. This is one of the issues to be clarified as part of the planned review of eligibility and entitlement legislation.

5.14 In addition, he noted that the report acknowledges that private patient services are estimated to account for 2-3% of laboratory services. In his view, the conclusions in the report should be

seen in the context that income of around €188m is earned by the public health services directly from charges to private patients. He informed me that this income has increased significantly over recent years.

6 Governance of Health Agencies

6.1 Health agencies are governed, at corporate level, by boards whose members are appointed by the Minister for a fixed period of time. The general role and responsibilities of boards can be summarised as follows

- overseeing the strategic planning and direction of the organisation
- supervising its management
- overseeing the organisation's financial objectives, plans and actions, including significant expenditures and material transactions arising in the ordinary course of business
- reviewing, adopting and publishing the annual financial statements of the organisation
- monitoring the organisation's performance against strategic plans and objectives
- ensuring ethical behaviour and organisational compliance with laws and regulations

6.2 I noted, in the course of audit, that the boards of some health agencies had not been reappointed or vacancies in the membership had not been filled. In some instances, the boards had not functioned for some time. The agencies in question included

- Tallaght Hospital Board
- Board for the Employment of the Blind
- Postgraduate Medical and Dental Board
- National Social Work Qualifications Board

6.3 I can only issue audit reports after the adoption by boards of these agencies' accounts. In the four health agencies in question the absence of boards has led to

- delays in finalising the financial accountability process
- inadequate oversight of the financial and operational management of the organisations, at a time of increased risk i.e. when they are in the process of, or close to, being wound up
- impairment of the functioning of the organisations as certain decisions that ought to be referred to and approved by the members of the board cannot be so approved.

Tallaght Hospital Board

6.4 Tallaght Hospital Board was established[18] in 1980 to build and operate a general hospital at Tallaght. The hospital was commissioned in June 1998 and responsibility for its management was vested in AMINCH, an entity representing the governing bodies of the Adelaide, the Meath and the National Childrens' Hospital at Harcourt Street. Tallaght Hospital Board has continued in operation to finalise remaining issues associated with the hospital's construction. Its current situation can be summarised as follows

- The term of the Board ended in 2002 and a new Board has not been appointed.
- Between 1999 and 2002 the Board met infrequently.

18 Tallaght Hospital Board (Establishment) Order, 1980

- The Board does not currently have an executive in place to support its operations.
- Because of the delay in accounting for the Board's past operations there is an absence of clarity on the Board's current financial state of affairs.

6.5 As a result of these circumstances, my Office has been unable to finalise the audit of the Board's accounts for financial periods from 1999 onwards. I enquired about the steps taken, or contemplated, by the Department to ensure that there are adequate corporate governance arrangements in place to

- oversee the operations remaining to be discharged by the Board and
- to ensure the orderly wind-up of the Board's affairs.

6.6 In response, the Department acknowledged that members of the Board must be reappointed to allow the Board's outstanding functions to be completed, including

- finalisation of the accounts for the period 1999-2002
- endorsement of a report by the Project Director evaluating the outcome of the hospital construction project
- completion of the review of the report by the Project Manager who supervised the construction of the hospital.

6.7 The Department informed me that a number of issues related to the re-appointment of the Board needed to be resolved and it had sought the advice of the Attorney General. On foot of this advice, the Department has begun the process of amending the statutory instrument under which the Board was first established. The amendment is needed to facilitate the re-appointment of Board members by identifying alternative nominating bodies to those which are no longer extant.

Postgraduate Medical and Dental Board

6.8 The terms of office of the board members of the Postgraduate Medical and Dental Board expired in March 2002. My Office was informed that no new appointments have been made because the future of the body is under consideration in the context of the proposed reorganisation of the health service. Prior to the expiry of its term of office the last Board approved a budget and passed resolutions designed to authorise certain expenditure in advance. However, the absence of a Board has

- prevented the adoption of the financial statements for the years 2001 and 2002
- removed high level oversight of the Board's financial and operational management.

6.9 Draft financial statements for both years in question have been produced by the administrative staff of the Board and audit fieldwork has been completed by my staff. However, I am unable to certify my opinion on the financial statements because they have not been approved formally by a board.

6.10 The current arrangements do not provide an adequate basis for authorising expenditure, or for discharging accountability requirements. Even if the Postgraduate Medical and Dental Board is dissolved, effective corporate governance arrangements would be needed to ensure the organisation's affairs are wound up in an orderly manner.

6.11 In acknowledging the situation, and to ensure appropriate corporate governance arrangements, the Secretary General of the Department formally agreed to have financial accountability arrangements transferred to him. These arrangements will operate on an interim basis pending the formal transfer of the Postgraduate Medical and Dental Board's functions to another body under the Health Service Reform Programme

Board for the Employment of the Blind

6.12 The Board for the Employment of the Blind, whose future had been under review by the Department for some time, is being abolished under the health service reform programme and its functions are being transferred to another agency.

6.13 The Chairperson of the Board resigned in 2000 and the Department did not appoint a successor. The remaining members of the Board have not met in formal session since December 2000. In effect, the organisation has been without a board since that time. My Office wrote to the Department on this matter in April 2002 and again in September 2002 but the Department did not respond. A decision to abolish the Board was announced in June 2003.

6.14 I have not been in a position to issue an audit report on the organisation's financial statements from the year ended 31 December 1999 to date. My staff have continued to audit the accounts of the Board in the intervening period in anticipation of the eventual appointment of a new board.

6.15 The closure of the Board means that there is an added urgency to finalise the accounting for the years from 1999 and to ensure that its affairs are wound down and its assets transferred in an orderly manner.

6.16 The Accounting Officer has informed me that the Minister has decided to appoint a new Chairperson and re-appoint other members of the Board. The Board will have the task of ensuring that its affairs are wound down and its assets transferred in an orderly manner.

National Social Work Qualifications Board

6.17 The National Social Work Qualifications Board is the recognition authority for social work qualifications in Ireland and the designated authority under EU regulations[19] for social work professionals. The Board's seventeen members are appointed by the Minister.

6.18 The terms of office for the members of the Board expired in April 2003 and new members were not appointed. The absence of a board prevented me from finalising the audit of the financial statements for year ended 2002 as the statements could not be approved without a board in place. In addition, as the board members are responsible for recognising social work qualifications, the absence of a board meant that this work had been in abeyance from April 2003 onwards. The situation was rectified in September 2003 with the appointment of a new board.

19 EU Directive 89/48.

Audit Conclusions

6.19 The absence of duly constituted boards in certain health agencies militated against the proper corporate governance of the agencies and the discharge of accountability for their operations.

6.20 The lack of a board also hampers decision making, authorisation of actions and organisational planning and coordination.

Response of the Accounting Officer

6.21 The Accounting Officer noted that my report outlined a number of difficulties in relation to organisations where boards were not in-situ and, therefore, proper accountability and governance arrangements were not in place. These matters have recently been addressed either by way of re-appointment of boards or the transfer of accountability to the Department.

6.22 He informed me that in the case of Tallaght Hospital a Statutory Instrument had recently been signed by the Minister and a limited number of board members appointed to deal with the outstanding issues. He drew attention to the fact that it was only in the case of four entities out of the total of 56 agencies, with statutory boards, in the health sector that delays in re-appointment of the boards arose and these had arisen for very specific reasons.

7 Property Management and Control

7.1 Up to 1996, health boards required the prior consent of the Minister before they could acquire or dispose of property. A 1996 Act[20] dispensed with the need to obtain the approval of the Minister and empowered boards to acquire and dispose of property, subject only to general directions that may be given by the Minister with the approval of the Minister for Finance.

7.2 The acquisition, management and disposal of property by the health boards and the ERHA are subject to the following general controls

- All capital development projects proposed by a health board require the specific and prior approval of the Department. In addition, projects costing in excess of €6.3 million require its approval at appropriate stages throughout their lifecycle and must be approved by the Department of Finance at design and tender stages.
- A health board must maintain a comprehensive register of all of its fixed assets, including property.
- Health boards are required by law to ensure that all property disposals follow normal procedure and that members of the health board are provided with details of the disposal.
- Health boards have a statutory obligation to ensure that all proceeds from property disposal are applied for capital purposes.

7.3 Audits carried out by my Office noted certain specific instances that appear to suggest that it may be necessary to review how the acquisition, recording and disposal of property is controlled and managed. These instances arose out of

- The replacement of the Eastern Health Board with the ERHA and three regional boards which gave rise to demands for additional accommodation.
- The construction of a headquarters building by the North Western Health Board without long-term funding arrangements being agreed with the Department.

East Coast Area Health Board

Southern Cross House

7.4 A task force established by the Minister decided to locate the headquarters of the East Coast Area Health Board (ECAHB) in Bray. In 2000, the ECAHB agreed a lease for this purpose on Southern Cross House at Southern Cross Business Park in Bray. The initial arrangement was for a letting of five years from March 2000 with an option during the first two years to negotiate a permanent arrangement. The area of the premises was 19,900 sq ft and the rent was set at €293,000 plus VAT per annum for the first two years and €354,000 plus VAT per annum for the final three years of the lease.

7.5 The cost of fitting out the premises amounted to €3.4 million. Part of this cost was capitalised and the remainder was absorbed from current revenue. The ECAHB has not received funding to clear the capital element of €1.6 million which is a deficit on its Capital Income and Expenditure Account. The Board intends to address this deficit by disposing of surplus property.

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20 Health Amendment (No.3) Act, 1996.

7.6 The ECAHB subsequently decided to vacate these premises in early 2004. This decision was taken in the context of a demand for accommodation in respect of approved service developments and the need to consolidate services.

Bray Civic Centre

7.7 The ECAHB, in late 2001, entered into an agreement for a lease for offices at Bray Civic Centre. The area of the premises is 36,700 sq ft. The agreement to lease is for a period of 25 years commencing in November 2003, at an annual rent of €803,000, subject to 5-yearly rent reviews. Fit-out costs of €3.8 million were incurred while the VAT on the capitalised value of the lease amounted to €1.12 million. These costs are included in the deficit on the Board's Capital Income and Expenditure Account at 31 December 2003.

7.8 The lease was entered into in the context of a planned growth in employee numbers to 116 by the beginning of 2002, due to approved service developments, many of which were national initiatives. The Board saw the Civic Centre as providing an adequate headquarters together with a new health centre and allowing for a process of consolidation of services in Bray.

7.9 In October 2002 the ECAHB sought legal advice on whether they could surrender the lease. The Board has explained that this advice was sought in the context of the Board informing itself of all potential relevant factors as part of its options appraisal process relevant to an accommodation crisis within the Bray area in the presence of ever increasing service pressures and financial uncertainty. It emphasised that the Board regularly obtains legal advice as part of its normal decision making process. The Board was advised that it is obliged to assume all obligations and responsibilities contained in the lease, and surrendering the lease, if the lessor would accept it, could be very costly.

7.10 Subsequently, having reviewed the capacity of both Southern Cross House and the Bray Civic Centre in the light of requirements, it was decided that the best option was to consolidate certain services and the head office functions in the larger Bray Civic Centre and surrender the Southern Cross House lease.

Views of the Chief Executive

7.11 In regard to the buildings at Southern Cross House and the Bray Civic Centre, the Chief Executive informed me that the Minister had established a task force charged with the responsibility of developing structures for the ERHA and the three Area Health Boards prior to their formal establishment on 1 March 2000. Part of this remit was to identify possible locations for Area Headquarters facilities and, where possible, to arrange for temporary accommodation prior to 1 March 2000. Bray was identified as the optimum location for the ECAHB.

7.12 The former Eastern Health Board had also, since 1987, been planning to develop a new Health Centre for Bray to service the growing population and deal with the unsatisfactory condition of the fragmented delivery arrangements that existed. As early as December 1996 a proposal to develop the Civic Centre as a Health Centre, on the ground floor and to utilise the second and third floors as offices had been mooted. However, significant planning permission and development difficulties were encountered which gave rise to a lot of uncertainty about the feasibility of the project. These matters were ultimately cleared in late 2001.

7.13 On 1 March 2000 approximately 1,000 sq ft were temporarily acquired from Bray Urban District Council in Southern Cross Business Park and this formed the temporary headquarters of

the Board accommodating six persons. At this juncture an initial staffing profile of 42 had been identified and the Board could not have been expected to anticipate the increase in staff which it was later obliged to accommodate.

7.14 During the time immediately prior to, and subsequent to, the setting up of the Board both the Estate Management Officer and the Task Force were actively seeking to acquire a more suitable headquarters for the ECAHB. During late February 2000 the Estate Management Officer had advised that Southern Cross House was on the market and suggested that it should be considered as a potential location for a new headquarters. A five-year lease was signed for 19,900 sq ft, effective from 1 March 2000. Provisional fit-out to allow occupation commenced on the first floor in early April 2000 and concluded on this floor in late July. Approximately 20 of the original 42 employees for which this premises was identified had transferred to this location by late August 2000. The fit-out of the remainder of the building was completed on a phased basis. This was easily facilitated since the Board had difficulty in recruiting its approved staffing complement.

7.15 The original design brief which took account of the initial staffing blueprint determined for the Board, together with some room for expansion, indicated that Southern Cross House would need to accommodate 52 employees. The complete fit-out was completed in June 2001. In September 2001, 52 employees were accommodated in Southern Cross House with a further 38 expected within three months.

7.16 During 2000 and 2001 the significant developments within the health services, particularly in the Eastern Region, gave rise to the creation of many additional approved posts within almost all sectors of the ECAHB. It was necessary, therefore, to plan for the long-term accommodation needs. It was in this context, and following the final settlement of outstanding difficulties in relation to planning of the Civic Offices, that the Board engaged with developers in 2001 to deliver a facility which could accommodate 143 staff at headquarters level, with the flexibility to accommodate 170, and develop a new health centre. This number can be accommodated because the building has been developed on a completely open-plan basis, with no individual office provision whatsoever.

7.17 The ECAHB decided that the only practical and most cost-effective approach to securing a modern healthcare facility, together with an adequate headquarters for the approved staffing complement, was to combine both within the Bray Civic Centre development, which had only then become a realistic and feasible proposal. This process will rectify the current situation of fragmentation of health services within the Bray area and deliver significant capacity. A sum of €3.3 million is being advanced by the ERHA to meet the costs. The resulting consolidation will also achieve cost and service efficiencies and result in the disposal of four rented properties.

7.18 The CEO explained that, in regard to the arrangements for the transfer to the Bray Civic Centre, the overall consolidation of frontline health service facilities and the headquarters was uniquely facilitated because the same landlord owned both Southern Cross House and the Bray Civic Centre. The Board negotiated a once-off payment of €315,000. This figure reflects the lease surrender costs to include augmentation to Southern Cross House as detailed by the landlord. All possible reusable elements of the original fit-out have been redistributed throughout the Board's services.

7.19 He informed me that, while the Board had an option to purchase the premises at the Civic Centre for €12.7 million, this option could not be considered in the context of the financial constraints that exist.

Parkgate Street

7.20 In June 2002, the ECAHB entered into a lease for around 22,400 sq ft of office accommodation in Parkgate Street on behalf of Eastern Health Shared Services (EHSS), which operates under its remit. The lease was for a period of 25 years from 1 December 2001 at an initial rent of €680,000 per annum. VAT on the capitalised value of the lease amounted to €762,000. The Board decided not to put the fitting-out work to tender, but to appoint the design team and contractor already on site. The fit-out contract price was set at €906,080. The outturn was around €1.3 million. At 31 December 2002 the total cost of fit-out, relocation and VAT charged to the annual accounts amounted to €3.6[21] million and is reported as a deficit on the Capital Income and Expenditure Account at 31 December 2003.

Views of the Chief Officer

7.21 The Chief Officer of the EHSS informed me that the principles of design team engagement were adhered to on this project as the members were on the approved consultants panel. It was advantageous to engage the in-situ architect and mechanical and engineering consultant to benefit from their existing knowledge of the shell and core project. The quantity surveyor, on the other hand, had not been involved in the shell and core project. This ensured that the service would get an independent opinion on the value for money that it would gain by negotiating with the in-situ contractor. The quantity surveyor undertook the detailed negotiations with the contractor with a clear mandate to ensure value for money, particularly in light of the time pressures on the fit-out.

7.22 The practical completion of the shell and core works had not been reached at that time with the result that the contractor still had his site management infrastructure in place and still had responsibilities to complete works on site. Due to extreme congestion in Dr. Steeven's Hospital, resulting in contravention of both fire and Health and Safety regulations, an urgency attached to the relocation of a significant number of staff from that location.

7.23 By engaging the existing contractor, considerable time savings were achieved. The commencement of fit-out work prior to completion of the shell and core contract could only be achieved by engaging the contractor undertaking these works.

7.24 The original contract was for the fit-out of the ground, first and second floors. During the contract approval was granted to fit out the third floor of the building. The final account figure for the project reflects this addition to the contract terms.

Northern Area Health Board

New Headquarters at Swords Business Campus

7.25 In May 2000, the Northern Area Health Board (NAHB) leased office space in Swords Business Campus for its corporate headquarters. The lease agreed was for 25 years, commencing on 1 September 2000, at an annual rent of €501,000, plus car parking and service charges of €57,000 and €71,000, respectively. The area of the premises was 28,200 sq ft and VAT on the capitalised value of the lease was €721,000.

21 This included VAT on the capitalised value of the lease (€0.76m), legal fees, amounts paid to the surveyor and architect as well as furniture costs and other minor capital works.

7.26 The premises acquired consisted of a shell of a building which required considerable construction work in order to fit it out as office premises. A design team and construction company were appointed to fit out the offices as headquarters for the NAHB. Capital expenditure to date on fitting out and associated costs amounts to €4.7 million. The breakdown of this amount is shown in Figure 7.1.

Figure 7.1 Cost of Northern Area Health Board Headquarters

	€m[a]
Main Construction Contract	2.88
Other contracts, including furniture	0.37
Professional fees	0.34
Equipping	0.23
VAT on capitalised lease	0.72
Other expenditure	0.16
Total	**4.70**

Source: Northern Area Health Board
a All amounts are inclusive of VAT.

7.27 The NAHB's capital income and expenditure account at 31 December 2003 included a deficit of €4.7 million in respect of the capital set-up costs of the headquarters.

7.28 The NAHB applied to the ERHA for €3 million in funding for the work in October 2000. However, funding had not been received at July 2004 and was still under negotiation with the ERHA and the Department at that time. The NAHB informs me that, in the meantime, the project has been funded by way of overdraft.

7.29 In response to my enquiries on the matter, the NAHB informed me that, although the Board needed funding approval, it was not required to obtain the Department's approval on the lease agreement itself[22]. The NAHB entered into the lease because it was required by the ERHA to commence health service operations in the North Dublin area as a matter of urgency. This entailed the provision of adequate accommodation, located in the functional area, for the headquarters staff assigned to the Board. The NAHB understood at all times that adequate capital and revenue financing would be forthcoming to allow it to meet its obligation under the new health management arrangements in the Eastern Region. The headquarters at Swords was established on foot of this understanding.

South Western Area Health Board

Headquarters at Millennium Park Naas

7.30 In April 2000 the Chief Executive Officer of the South Western Area Health Board (SWAHB) proposed to the Board that the acquisition of a premises at Millennium Park, Naas would meet its headquarter needs. The SWAHB accepted this recommendation and the CEO was authorised to pursue the acquisition of the headquarters building. In July 2000 the CEO reported to the Board that a 25 year lease was being negotiated and when finalised it would be brought to the

22 The requirement that health boards seek Department approval for property acquisition and disposal was removed under Section 17 of the Health Amendement (No. 3) Act, 1996.

Board for approval. The Board signed a lease for the offices in July 2001. The area leased is 39,195 sq ft and the rent is €771,000 per annum excluding parking spaces and service charges. VAT on the capitalised value of the lease was €754,000.

7.31 In October 2000 the CEO established a project team to oversee and manage the headquarters project. This project team noted that there would be no need to go to tender for fitting out the premises if the builders of Millennium Park were employed to carry out the work. The recommendation to have the fit-out carried out by the landlord's builder was supported by a quantity surveyor's report which said that there would be no unnecessary delays, less confrontation, competitive prices and greater productivity. The construction outturn was €3.28 million including VAT while associated fit-out costs, including professional fees and furniture, amounted to just under €1.1 million. The project was funded from the proceeds of the sale of assets.

7.32 The CEO informed me that the Board consulted with relevant expert opinion in determining the direction of the project. The expert advice was, in best practice and given the urgency of the situation, to negotiate the fit-out with the owners of the property. This approach facilitated the early completion of the fit-out project, which was necessitated by the urgent requirement to establish a presence within SWAHB's region and to facilitate the transfer of staff and was, in that context, best value to the Board. The CEO also informed me that the Board is satisfied that best practice was applied in respect of national and EU procurement rules in relation to the fitting out of the property. Tenders were sought in respect of the furniture and canteen services for the property.

North Western Health Board

New Headquarters at Manorhamilton

This matter was the subject of a report by the C&AG under Section 6 of the C&AG (Amendment) Act, 1993. A copy of that report is included at Appendix A.

7.33 In March 2001 the North Western Health Board (NWHB) concluded a contract for the construction of a headquarters building at Manorhamilton, Co Leitrim at a cost of €8 million. The contract was to include construction, fitting out and furnishing. However, it appeared that the Board had entered the contract without firm arrangements in place to fund this expenditure.

7.34 Following my enquiries on the matter, the Chief Executive Officer (CEO) of the Board informed me that in 1998, the NWHB had identified problems with the existing headquarters buildings

- The buildings did not comply with building regulations and with health and safety regulations and this was causing industrial relations problems
- The buildings, constructed in 1974 and augmented by a former workhouse, had by 1998 become inadequate as an integrated corporate facility.

7.35 The Board set about considering options to address the deficiencies of the existing building. It rejected an initial proposal to extend and refurbish the existing buildings, at an estimated cost of €857,000, on the basis that it would not be sufficient to deliver on the need to have an integrated central facility.

7.36 The Board set about developing specifications for a new headquarters building that would encompass the following

- the building should be a model of a healthy work environment and set a standard in terms of compliance with health and safety obligations
- the building and its facilities should combine utilitarian features with an appropriate civic ambience and should be self-contained
- the building should include a high-tech training environment
- the entrance foyer and reception area facilities should incorporate a physical design which reflects the best and latest in terms of dealing with customers
- appropriate on-site catering and other facilities to enable staff interaction should be provided
- the design concept should be symbolic in relation to the concepts of health promotion from both the staff and public perspective
- provision of meeting rooms, interview rooms, training and library facilities should be included in the building
- the new building should reflect the status of the Board as the largest employer in the North West
- the building should make a definite and positive contribution to the built environment.

7.37 As part of this process, the Board decided to extend the size of the proposed building to provide for future expansion and to cater for the smooth integration of the various functional departments within the building. In September 1999, the Board approved the new site and design plan for the building and in March 2000, received planning permission for the proposed building on a site adjoining Our Lady's Hospital, Manorhamilton.

7.38 The building contract was advertised in the Official Journal of the European Communities with a closing date for tenders in December 2000. The tender report from the Quantity Surveyors, received in February 2001, recommended a contract in the amount of €8 million (including VAT, loose furniture, blinds and audio visual equipment). The contractor commenced on site in May 2001 and the Board has been in occupation of the new building for some time now. While the project's cost outturn had not been finalised, construction and fit-out costs to completion are expected to total around €8 million. Professional fees of €1.2 million and commissioning costs of €0.3 million will bring the total cost to around €9.5 million.

7.39 The Board considered that funding by way of a loan, which would be significantly self-financing and cost-effective, was the preferable funding option. It calculated that the savings on property rental and other charges would amount to €447,000, savings on rental of rooms for board meetings, training and other purposes would amount to €100,000 and savings on travel and subsistence would amount to €150,000 giving an overall saving of €697,000 per annum. These economies would exceed the cost of loan repayments over a period of 20 years. Further savings were anticipated from the use of technology and the utilisation of the existing building for an expansion of community-based services and for the development of social day-care services for older persons, all of which would reduce the requirement for further new capital works to respond to those needs.

7.40 Accordingly, the Board sought approval from the Department for a loan to finance the project in July 2001 and again in late 2001. The Department made the Board aware that the current policy of the Department of Finance was not favourable to the grant of approvals for borrowing. In the meantime, the NWHB has funded the construction costs from the proceeds of its disposals of fixed assets (amounting to €4.1 million at the end of 2002) and from working capital. The Board is continuing its attempts to obtain sanction from the Department for a loan facility to provide the cash resources for this project.

7.41 The Accounting Officer of the Department informed me that the Department had no involvement in the decision to proceed with the project or with its procurement. The Department has not issued any approval or funding for the project. The construction of the project had commenced prior to the Department becoming aware of the development.

7.42 He informed me that the Department understood that the estimated cost in the original design brief was almost €0.9 million, at July 1998 costs. That brief envisaged the alteration and extension of the existing building. An option appraisal was carried out by the design team, following its appointment by the Board for the project, and this indicated that the Board's accommodation needs could not be met from the design brief's requirements and budget costs. The scope and functional content of the project was then revised and the Board decided to proceed with a new headquarters building without any agreement from the Department. As the original estimate for the project was less than €1.27 million, the design team appointment was in accordance with government public procurement procedures. However, the fees for the current project exceed the threshold above which advertising in the EU Journal is obligatory. This would have been known to the health board at the time of the option appraisal and it should have taken appropriate action to regularise the procedure then.

7.43 The CEO informed me that this was not done because

- The knowledge of the project which the existing design team had acquired during the feasibility stage would have been lost had the design team not been re-appointed.
- Design team fees to that stage would have to be re-incurred.
- Approximately six months would have been lost to the project.

7.44 The Accounting Officer stated that the Department only became aware of proposals for this project in July 2001 when the NWHB sought approval, in principle, to secure a loan of €8.2 million for the project. In November 2001 the Board again wrote to the Department stating that it sought to develop the HQ project and also Community Care facilities at Sligo. The Health Board proposed that both projects would be developed through borrowing of €17.4 million. Following discussions between the Health Board and the Department on the potential for loan funding, the Board wrote to the Department indicating the nature of the rental commitments it planned to liquidate and to utilise to fund the proposed borrowings.

7.45 Department approval for the project, or the associated loan, was not given. The Department has not agreed to provide any funding for the building, nor has it agreed that the building may be funded or part-funded by way of a charge against the health board's non-capital moneys.

7.46 The Accounting Officer informed me that it was made clear to the Board on several occasions that the Department was not in a position to advance approval for the borrowing proposed. It was also clarified that Department of Finance sanction would be required for any

such funding arrangement and in the opinion of the Department, the proposals submitted would not secure Department of Finance sanction.

Audit Conclusions

7.47 Accommodation of staff of new boards established under the ERHA in 2001 and a new Health Centre in Bray has given rise to annual payments of the order of €2.9 million and once-off payments of € 21.7 million.

7.48 Capital expenditure was incurred on two new headquarters buildings without having a permanent source of funding in place.

7.49 The failure to properly plan accommodation requirements in Bray led to a €3.4 million fit-out of a building which was only partly used for four years before being vacated.

Response of the Accounting Officer

7.50 The Accounting Officer stated that under 1996 legislation health boards did not require the approval of the Minister or the Department to acquire or dispose of property. The establishment of the ERHA, in particular, resulted in the setting up of five entities as replacement for one and gave rise to a significant property need.

7.51 It is a matter for the individual boards to organise their accommodation needs in an efficient and effective manner, ensuring that the normal parameters and procurement procedures are adhered to, and that value for money is achieved.

Appendix

North Western Health Board

Report of the Comptroller and Auditor General for presentation to the Houses of the Oireachtas

This report has been prepared pursuant to Section 6 (4) of the Comptroller and Auditor General (Amendment) Act, 1993.

1. Construction of new Headquarters

Legal Framework for Capital Expenditure by Health Boards

Prior to the introduction of the Health (Amendment) (No.3) Act, 1996 where a health board proposed to acquire or dispose of any land under its control, there was a specific requirement to obtain the consent of the Minister. Upon the passing of the 1996 Act into law, the statutory obligation of the Minister continued to apply in cases where the transaction was initiated and commenced prior to the enactment date.

Section 3 of the 1996 Act defined specific functions known as "reserved functions" and granted these exclusively to the Boards of the health boards. Section 18 of that Act provides that as part of these reserved functions, the Boards may acquire or dispose of land subject to any general directions given by the Minister with the consent of the Minister for Finance. The proceeds of sale of land is to be applied to a purpose to which capital money may be properly applied by the Board.

Section 17(d) of the 1996 Act provides that a health board may not borrow money without the prior consent of the Minister for Health and Children given with the concurrence of the Minister for Finance and the borrowing shall be subject to such terms and conditions (if any) as may be specified by the Minister with the consent of the Minister for Finance.

The period since 1996 has seen the full introduction, by the Department of Health and Children, of accounting standards for health boards which were formulated on the basis of professional standards and reflect fully the new accountability for capital asset expenditure and disposal under the control of the health boards. The Department's standards reflect the principles advocated in the 1996 legislation in that all capital proceeds from disposals must be applied to further capital purposes or future capital acquisitions.

Audit Concern

In the course of the audit of the 2001 financial statements, I noted that in March 2001the Board had concluded a contract for the construction of a headquarters building at Manorhamilton, Co Leitrim. The total value of the contract including VAT was £6,331,047 (€8,038,771). This cost included the costs of construction, fitting out and furnishing. As it appeared that the Board did not have firm arrangements in place to fund this expenditure I asked the Chief Executive Officer if the prior approval of the Department of Health and Children had been obtained for the project and the source of funding for the development.

CEO's Response

Origin of Project

The CEO traced the origins of the project back to June 1998 when the Board's Technical Services Officer submitted a report to the CEO in relation to headquarters' offices. The buildings were identified as being non-compliant with building regulations and the Safety, Health & Welfare at Work Act 1989. The latter had been highlighted on many occasions by the staff Trade Union in industrial relations meetings with Board management. The existing buildings, built in 1974 and augmented by a former workhouse, had by 1998 become significantly inadequate in terms of functioning as an integrated corporate facility. A process was then initiated to define requirements and consider the options in relation to addressing the established shortcomings in the existing facilities. Two main options were identified, namely:

- upgrade the existing offices together with an extension
- a complete new building.

This report recommended the new build option for further evaluation.

In July 1998 the Board prepared an outline planning brief for a refurbishment/new build with an initial cost estimate of €857,000. Architects were invited to make presentations for a part refurbishment/part new build project. Following consideration of these presentations a recommendation to appoint a firm of architects was approved by the Board.

In August 1998, under instruction from the Board, the architects submitted a draft Development Control Plan for headquarters recommending refurbishment/extension of the existing building. Following detailed assessment and review, the Management Team decided that an extension/refurbishment would not be sufficient to deliver on the need to have an integrated central facility.

At this stage a formal project team, representative of the full Management Team, was delegated responsibility for the project. This team was chaired by an Assistant Chief Executive Officer. At a meeting on 8 February 1999 the project team considered the issue of what should be based at corporate headquarters, the number of staff to be based there, and the common facilities to be provided including training rooms, meeting rooms, interview rooms, boardroom, library etc. Following this a discussion document was considered and approved by the Board's Management Team in February 1999.

The basis of this document was that in designing an effective headquarters the process should begin by defining the corporate strategy including the main sources of corporate value creation. The process should then draw out key/core principles derived from the corporate strategy on the role that corporate management and staff would be expected to play in its successful implementation. It should then conclude with detailed decisions about what functions should be located in corporate headquarters, how they would interact, what specific responsibilities should be, how they should be staffed, and how they should relate to the service users at the centre or throughout the Health Board.

Arising from this the critical design considerations to be included in the brief for the new corporate head office facilities were:

(a) the building should provide a model healthy work environment and set a standard in terms of compliance with health and safety obligations

(b) the building and its facilities should combine utilitarian features with an appropriate civic ambience and should be self contained

(c) the building should provide a high-tech training environment

(d) the entrance foyer and reception area facilities should incorporate a physical design which reflects the best and latest in terms of dealing with customers

(e) appropriate on-site catering and other facilities to enable staff interaction should be provided

(f) the design concept should be symbolic in relation to the concepts of health promotion from both the staff and public perspective

(g) provision of meeting rooms, interview rooms, training and library facilities should be included in the building.

(All of these were singularly lacking in the existing buildings)

(h) the new building should reflect the status of the Board as the largest employer in the North West

(i) the building should make a definite and positive contribution to the built environment

Progressing the Project

The Board then set about formalising the brief and engaged in consultation with staff on the design review. A draft schedule of accommodation was produced and proofed against the Corporate Headquarters Strategy document.

At this stage it was apparent that the project which would be required to meet the stated needs would push costs above the EU Procurement directive threshold for services. This would have required disengaging the Design Team and procuring a new one. This was not done because

1. The knowledge of the project which the design team had acquired during the feasibility stage would have been lost had the design team not been re-appointed.

2. Design team fees to that stage would have to be re-incurred.

3. Approximately six months would have been lost to the project.

The design team were then instructed to prepare outline drawings in relation to project options. On detailed consideration of these outline drawings in the context of the strategic vision for corporate head office facilities it became apparent that the footprint of the proposed building needed to be

extended to provide for future expansion - a sound and reasonable aspect to good planning and to cater for the smooth integration of the various functional departments within the building.

At this stage a detailed appraisal was carried out in relation to possible sites for the building and the recommendation was that the new building should be provided on a site adjoining Our Lady's Hospital, Manorhamilton.

In June 1999 the architect was requested to produce a site plan and a conceptual design plan for the proposed building. In September 1999, the Board's Management Team approved the plans and the design principles proposed. In December 1999 application was made for planning permission followed by a Fire Certificate application.

Planning permission was granted in March 2000 and in May 2000 a PIN notice was advertised in the OJEC. ln August 2000 a works notice was advertised in the OJEC with a closing date for tenders of 6 December 2000. The tender report from the Quantity Surveyors was received in February 2001 with a recommendation in the amount of €8,038,771(to include VAT, loose furniture and blinds and audio visual equipment). The contractor commenced on site on 16 May 2001.

The Board have been in occupation of the new building for some time now. While the project's final accounts will not be signed off for some time yet (under normal procedures), the cost report dated 10 March 2003, shows the approved contract cost at €8,146,111, an increase of just €107,000 (1.3%) on the contract price.

Funding and Costs

The CEO informed me that the Board viewed the project as being totally separate from the programme of service infrastructural development, which was being undertaken under the auspices of the National Development Plan. Thus capital funding was not sought from the Department of Health and Children for the project.

The Board considered that alternative funding by way of a loan, which would be significantly self financing and cost effective, was much more preferable and realisable. The Board calculated that the savings on property rental and other charges would amount to €447,000, savings on rental of rooms for board meetings, training etc. would amount to €100,000 and savings on travel and subsistence would amount to €150,000 giving an overall saving of €697,000 per annum. These economies would exceed the cost of loan repayments over a period of 20 years. Further savings are anticipated from the use of technology and the utilisation of the existing building for an expansion of community based services and for the development of social day care services for older persons, all of which reduce the requirement for further new capital works to respond to these development needs.

Having decided against NDP funding the Board sought approval from the Department for a loan to finance the project in July 2001 and again in December 2001. The Department of Health and Children made the Board aware that the current Department of Finance policy was not favourable to the granting of approvals for borrowing. At no stage did the Department of Health and Children indicate that the proposal in itself was intrinsically unsound.

In the meantime the North Western Health Board has funded the construction costs from the proceeds of disposals of fixed assets (amounting to €4.1 m at the end of 2002) and from funding generated from the management of working capital.

The CEO informed me that the total costs incurred to the end of December 2002 were:

Construction costs	€5.5m
Professional Fees	€0.9m
Total	€6.4m

He also informed me that additional costs to completion are:

Construction costs	€2.5m
Professional fees	€0.3m
Commissioning	€0.3m

This will result in a final cost of €9.5m.

The CEO said that the Board is continuing its attempts to obtain sanction from the Department of Health and Children for a loan facility to provide the cash flow for this project.

The Views of the Department of Health and Children

The Accounting Officer of the Department of Health and Children informed me that the Department only became aware of proposals for this project in July 2001 when the North Western Health Board sought approval from the Finance Unit for a loan of £6.5m (€8.2m) for the proposed project. No Departmental approval for the project, or the associated loan, was obtained. The project has not been indented by the Board to be funded under their National Development Plan. The Department has not agreed to provide any funding for the building, nor has the Department agreed that the building may be funded or part-funded by way of a charge against the Board's non-capital moneys. No sanction has been sought or obtained from the Department of Finance for this project.

The Accounting Officer also stated that the Hospital Planning Office of the Department had no involvement in the procurement of the project. The Department's understanding of the project is that the estimated cost for the building in the original design brief (July 1998 costs) was £0.7m (€0.89m). This design brief and budget cost was for the alteration and extension of the existing building. An option appraisal carried out by the design team, following its appointment by the Board for the project, indicated that the Board's accommodation needs could not be met from the design brief's requirements and budget costs. The scope and functional content of the project was then revised and the Board decided to proceed with a new HQ building without any agreement from the Department.

The Accounting Officer also noted that, as the original estimate of the project was less than £1.0m, the design team appointment was in accordance with government public procurement procedures. However the fees for the current project exceed the threshold above which advertising in the EU Journal is obligatory. This would have been known to the Board following the option appraisal and it should have taken appropriate action to regularise the procedure at that time.

Regarding the request for loan approval, the Accounting Officer said that in July 2001 the North Western Health Board wrote to the Department's Finance Unit giving a brief outline of the project which had an estimated cost of £6.5m (€8.25m) and seeking approval in principle to secure a loan for the project. In November 2001 the Board again wrote to The Department stating That it sought to develop the HQ project and also Community Care facilities at Sligo. Both projects were proposed to be developed through borrowing of £l3.7m (€17.4m). Following discussions between the Board and the Department on the potential for loan funding, the Board wrote to the

Department indicating the nature of the rental commitments the Board planned to liquidate and to utilise to fund the proposed borrowings.

The Accounting Officer informed me that it was made clear to the Board on several occasions that the Department was not in a position to advance approval for the borrowing proposed. It was also clarified that Department of Finance sanction would be required for any such funding arrangement and in the opinion of the Department of Health and Children, the proposals submitted would not secure Department of Finance sanction.

The Accounting Officer emphasised that the Department had no involvement in the decision to proceed with the project, no approval or funding has issued and the construction of the project had commenced prior to the Department becoming aware of the development.

2. Shortcomings in Internal Controls

The Board operates an automated purchasing system designed to ensure that

- goods and services are only ordered when appropriately authorised
- payment for such goods is only made when the Board has satisfied itself that the goods and services have been received
- expenditure in relation to the purchase of goods and services is properly recorded in its books of account and in the annual financial statements.

The system operates in the following way. In each of the almost one hundred cost centres within the Board there are approved personnel (buyers) who are responsible for ordering goods and services. Buyers are required to generate electronically a Purchase Order which records details of the goods or services and the appropriate cost centre and expense code. Generally speaking, a Purchase Order should only be generated in response to a requisition signed by a budget holder.

When goods or services are received at the various locations they are checked against the relevant Purchase Order for quantity and quality. If satisfied, a designated receiver of goods other than the buyer will generate a Goods Received Note (GRN) electronically. The creation of a GRN acts as confirmation that goods or services have been properly authorised, that they have been received and that payment may be made in due course on foot of a supplier's invoice.

When an invoice is received it is checked against open GRNs. If it is matched the GRN is closed on the system and the invoice is recorded as matched and payable.

Cheques are issued centrally and are triggered by requesting the system to pay all matched invoices up to a certain date. When an invoice is not matched with an open GRN it should be referred to the relevant buyer to resolve the discrepancy prior to processing the invoice for payment.

If the purchasing system operates correctly the Board can be assured that goods and services ordered and paid for through the system have been properly authorised and that payment has only been made in respect of goods and services actually received.

The system also allows the Board to ensure that its books of account are kept up to date by recording all expenditure as it is incurred. In particular, the aggregate value of open GRNs at the end of any period represents expenditure incurred by the Board on goods and services during that period where the relevant invoice has not yet been processed.

The Board also has a system for paying certain expenditure outside the purchasing system. This is intended to be used only to pay certain items such as utility bills where the costs of the service are not known in advance. It is not intended to be used for the bulk of the Board's expenditure on goods and services.

During the 2002 audit, and prior to the conclusion of the 2001 audit, I conducted additional work to verify the reliability of the accruals contained in the Board's financial statements. As a result of this work, it came to light that the Board's purchasing system was not operating as originally intended. In particular, it became clear that the figure for open GRNs recorded in the Board's books of account at the end of 2001 was overstated by a significant amount. The Board had recognised this fact itself in 2001 and made a provision of €451,000 in the financial statements against the apparent overstatement pending a full reconciliation of supplier invoices.

In response to enquiries which I raised in relation to the operation of the purchasing system, the Board decided in August 2003 to commence a full reconciliation of the creditors and accruals recorded in its books against supplier statements. That exercise has confirmed that accruals at 31 December 2001 are overstated. It is not possible to determine the amount of the overstatement but based on the reconciliation recently completed by the Board it is estimated at €2m. It follows that the accumulated deficit at 31 December 2001 is overstated by the difference between this amount and the provision already made i.e. by approximately €0.6m.

I asked the CEO to explain how the overstatement came about. The CEO informed me that the bulk of the overstatement occurred because the system had been bypassed by paying some invoices without going through the matching process. In addition, in some cases goods received and recorded on GRNs may have been subsequently returned without the GRN being adjusted.

The CEO has assured me that in making a provision against the apparent overstatement of the "goods received not invoiced" accrual the Board recognised that a full reconciliation of the accrual with supplier statements was required.

He informed me that this reconciliation had now been completed and is the basis on which an adjustment has been made to 2002 accounts. The invalid GRNs identified have been removed from the system, cumulative expenditure has been adjusted and the Balance Sheet as at 31 December 2002 has been revised to reflect actual liabilities.

He further stated that no advantage accrued to the Board as a result of the overstatement of expenditure in 2001 as the resultant overrun had to be treated as a first charge on the 2002 allocation.

A number of steps have been taken to reinforce existing control procedures to ensure that the problem does not recur

- training has been undertaken with staff to ensure that standing accounting control procedures are complied with
- a certification process has been introduced to ensure that goods received through the purchase ordering system are not paid without going through the matching process
- additional training has been provided to buyers in relation to the return of goods
- monthly control reporting has been introduced to monitor the age and value of GRN records on the system and facilitate the maintenance of accurate accrual records
- systems for routine creditor reconciliation have been revamped and additional resources allocated to this role
- additional focus has been placed on all Balance Sheet/Control Account reconciliations.

The CEO also assured me that the net outcome of this issue is a stringent focus on observation of and compliance with the Board's policies and control procedures in all areas. The Audit Committee of the Board have been fully apprised of the situation as have the Internal Audit function and both will be monitoring the position going forward.

John Purcell

Comptroller and Auditor General

22 December 2003