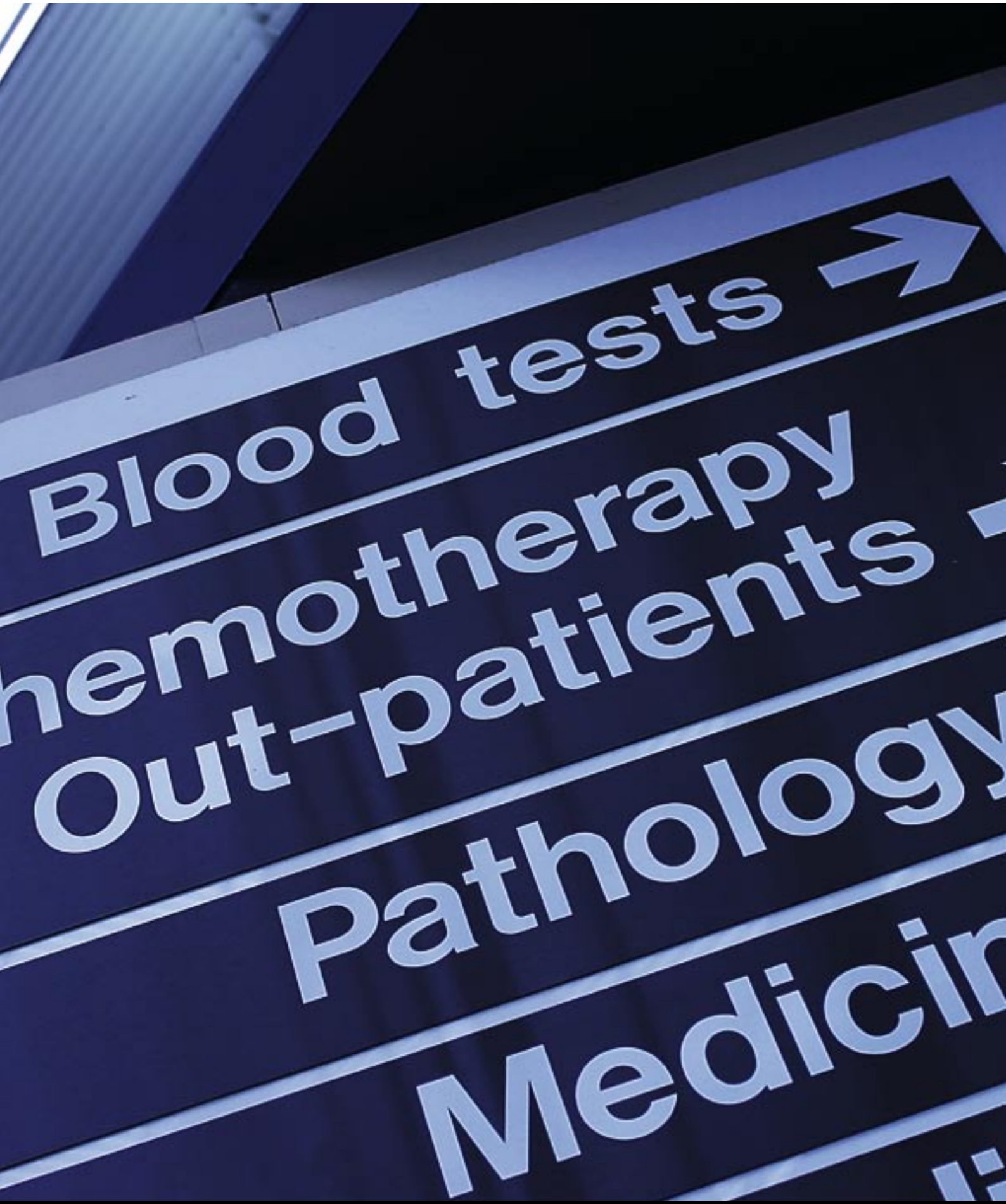
NAO
NATIONAL AUDIT OFFICE

HEALTH FOCUS



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WELCOME

Welcome to this first issue of NAO Health Focus, which replaces our previous Chief Executive briefing. It sets out what we have been doing over the past year and where we are heading in the future and we hope you will find it helpful and informative. It will also let you know some of the important recommendations we have made that may affect the area of the NHS that you are involved in.

Much has happened in the year since the last edition of this briefing in Spring 2004. We have published seven health value for money studies and two studies on PFI and PPP arrangements in the health sector. Many of our reports have been examined by the Committee of Public Accounts, the senior select committee of the House of Commons, which produces its own report and recommendations that the government have to respond to in the form of a Treasury Minute. Full copies of these reports and related materials are available from our website (www.nao.org.uk) and the website of the Committee of Public Accounts (www.parliament.uk/parliamentary_committees/committee_of_public_accounts.cfm). We have also hosted conferences on health and safety in the NHS and cancer care and spoken about our report findings at numerous events. I hope some of you have been able to attend these events to see for yourselves the positive contribution we are making to NHS organisations and the delivery of patient care.

One important recent development that we believe will genuinely benefit NHS organisations is the June 2004 Concordat agreement between the organisations with responsibilities for inspecting, regulating and auditing healthcare. The aims of the agreement are to deliver a more consistent and coherent programme of inspection, to improve services for patients, clients and their carers and to provide a more effective approach to audit and inspection. We are signatories to the Concordat and, as a member of each of the Concordat working groups, we are actively involved in helping to deliver its aims. You should begin to notice the results over the coming months and years.

We have recently undergone some important changes within the NAO. Most notably my predecessor, Jeremy Colman, has been appointed as Auditor General for Wales. I have taken over Jeremy's role of Assistant Auditor General with responsibility for the Department of Health and PFI/PPP. I am really excited by the joint challenges we face in modernising the health sector and look forward to meeting many of you over the coming months. Here at the NAO we have welcomed Chris Shapcott to the team as a Director of Health VFM alongside Karen Taylor. Chris will also have some responsibility for PFI with James Robertson.

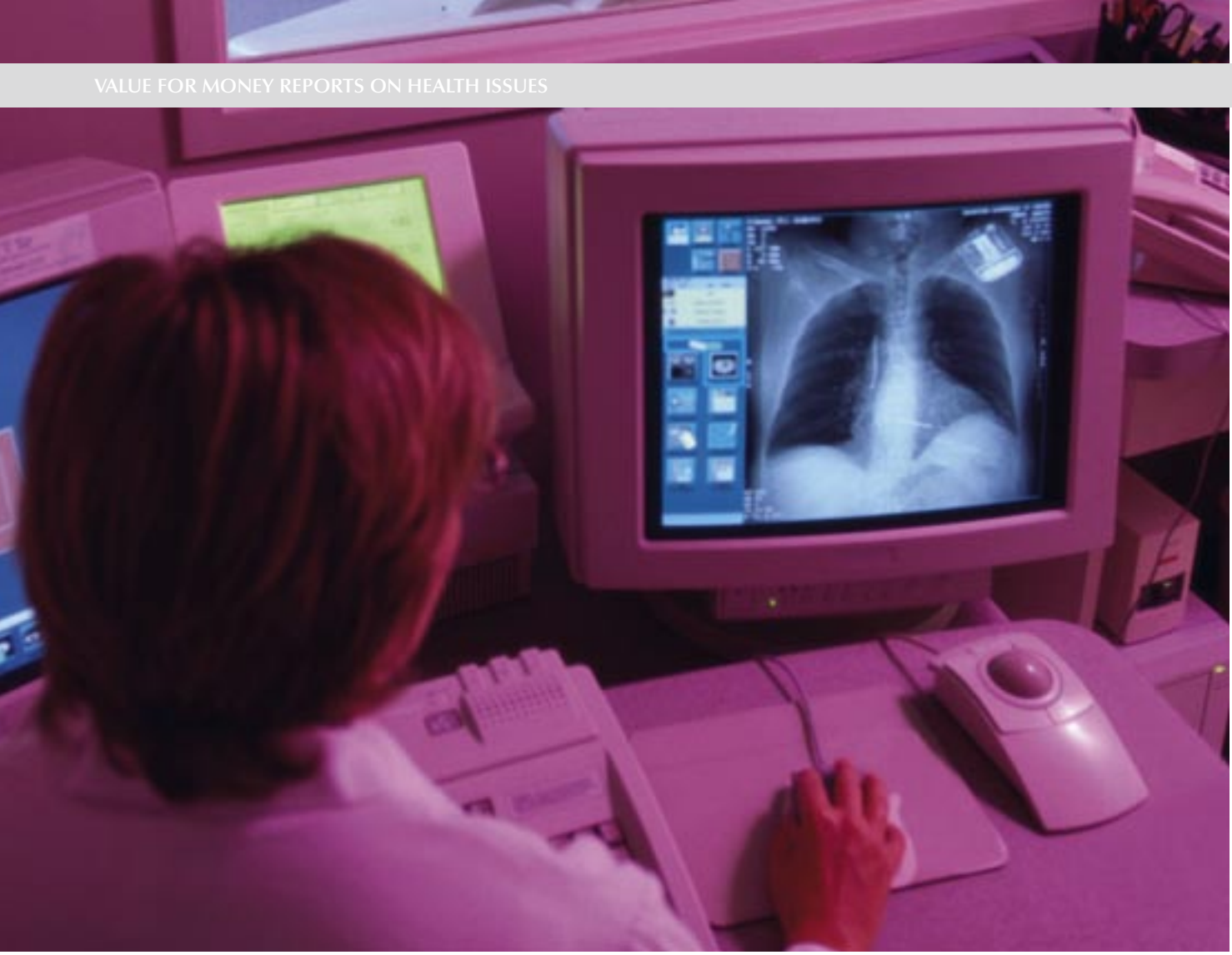
Finally, as always, we welcome your input and ideas for areas that you think we should examine, and we are keen to respond to your needs. If you feel an NAO examination could improve the delivery of a service, help identify and spread good practice or highlight areas of concern, we would like to hear from you. Please do not hesitate to contact me directly at anna.simons@nao.gsi.gov.uk.

Anna Simons.

Anna Simons
Assistant Auditor General

WHAT'S NEW?

Since our last briefing, we have published ten reports, all of which are available from our website (www.nao.org.uk). The website also contains other information you may find of interest such as the results from many of the surveys we undertook to support our findings. The following are a series of brief summaries of the ten reports published in the past year along with key recommendations from the Committee of Public Accounts report if one has been published or key recommendations from the NAO report if not. The Committee of Public Accounts reports can be found in full on their website (www.parliament.uk/parliamentary_committees/committee_of_public_accounts.cfm).



SAVING MORE LIVES

Tackling cancer in England: saving more lives (March 2004)

The report found that cancer patients are increasingly surviving the disease as a result of the new initiatives launched by the Department of Health and the NHS over the last decade. The recorded incidence of cancer has grown by 31 per cent since 1971, partly due to more comprehensive data collection and partly due to lifestyle trends such as smoking and increased exposure to sunlight. However, survival rates are up and death rates have fallen by 12 per cent in the last 30 years, although progress varies by type of cancer.

The NHS needs to continue to do more to ensure all patients are treated swiftly and appropriately. Delays in diagnosis are a continuing problem and there are still inequalities in the availability of some treatments, such as approved drugs, and in timely access to other interventions, such as radiotherapy. The report called for the Department to work with groups of patients who are diagnosed with cancer at an advanced stage in order to understand why they did not seek medical advice earlier and so action can be taken to encourage more patients to come forward earlier with symptoms. Those most strongly suspected by GPs of having cancer are now assessed promptly, but a significant proportion of those with cancer have not been referred urgently and have therefore had to wait a number of weeks longer for assessment by a consultant.

The Committee of Public Accounts report's recommendations include:

- The Department should publicise some simple guidelines to help people recognise and act on appropriate symptoms for major cancers;
- Action is needed to help GPs improve their ability to identify symptomatic patients; and
- A deadline should be set for ending the current wide variations in prescribing of anti-cancer drugs such as Herceptin.

HOSPITAL ACQUIRED INFECTION

Improving patient care by reducing the risk of hospital acquired infection: a progress report (July 2004)

The best available estimates suggest that each year more than 300,000 patients acquire an infection, around 5,000 die as a result, our MRSA rates are amongst the worst in Europe and hospital acquired infections cost the NHS £1 billion. Our report, which was a follow up to our report in 2000[1], showed that there is still a lack of robust comparable data on infection rates, other than MRSA bloodstream infections, and the information that is available suggests that rates are increasing. The emergence of strains of multi-resistant bacteria has increased the complexity of managing and controlling infection.

Whilst there has been notable progress in putting the systems and processes in place, wider factors, such as high bed occupancy rates, continue to impede good infection control. There are wide variations in compliance with good infection control policies and procedures, for example, on antibiotic prescribing, hand hygiene, catheter care and environmental cleanliness. Staff remain concerned about the lack of suitable isolation facilities and the increased frequency with which patients are moved within hospitals and that there is insufficient separation of elective and trauma patients. Patients continue to highlight concerns about standards of cleanliness and the risk of MRSA.

Since publication of our report, Health ministers have made it a top priority for hospitals to improve cleanliness and lower both healthcare acquired infection and MRSA rates. In particular, they have introduced a target for all NHS trusts to reduce MRSA bloodstream infection rates by 50 per cent by 2008.

The Committee of Public Accounts report's recommendations include:

- NHS trusts' implementation of these Departmental cleanliness initiatives should be evaluated by an annual survey to see that they are actually improving cleanliness on the wards. All trusts should also put in place measures to ensure that they tell patients what they can expect and that they obtain patients views on ward cleanliness. The Department should determine whether hygiene assessments and cleaning methods used by the food and hospitality industries could improve consistency and reduce the subjectivity of cleanliness assessments.
- Strategic Health Authorities should ensure that all NHS Trusts have carried out a risk assessment of their isolation facilities, in line with Health and Safety legislation, and work with them to determine a timetable and resourcing strategy to address identified shortfalls in requirements.

1 The Management and Control of Hospital Acquired Infection in NHS Acute Trusts in England (HC 230 Session 1999-2000).

EMERGENCY CARE

Improving emergency care in England (October 2004)

In 2000, in response to patient concerns, the Department set a range of emergency care access targets in the NHS Plan. Some 16 million people now use emergency care services each year with around 13 million attending Accident and Emergency departments in acute hospitals, and numbers are rising. As a result A&E departments are effectively the "shop windows" of the NHS for many people. The key performance management target was to reduce the time spent from arrival to admission, transfer or discharge to less than 4 hours for 98 per cent of patients by the end of 2004.

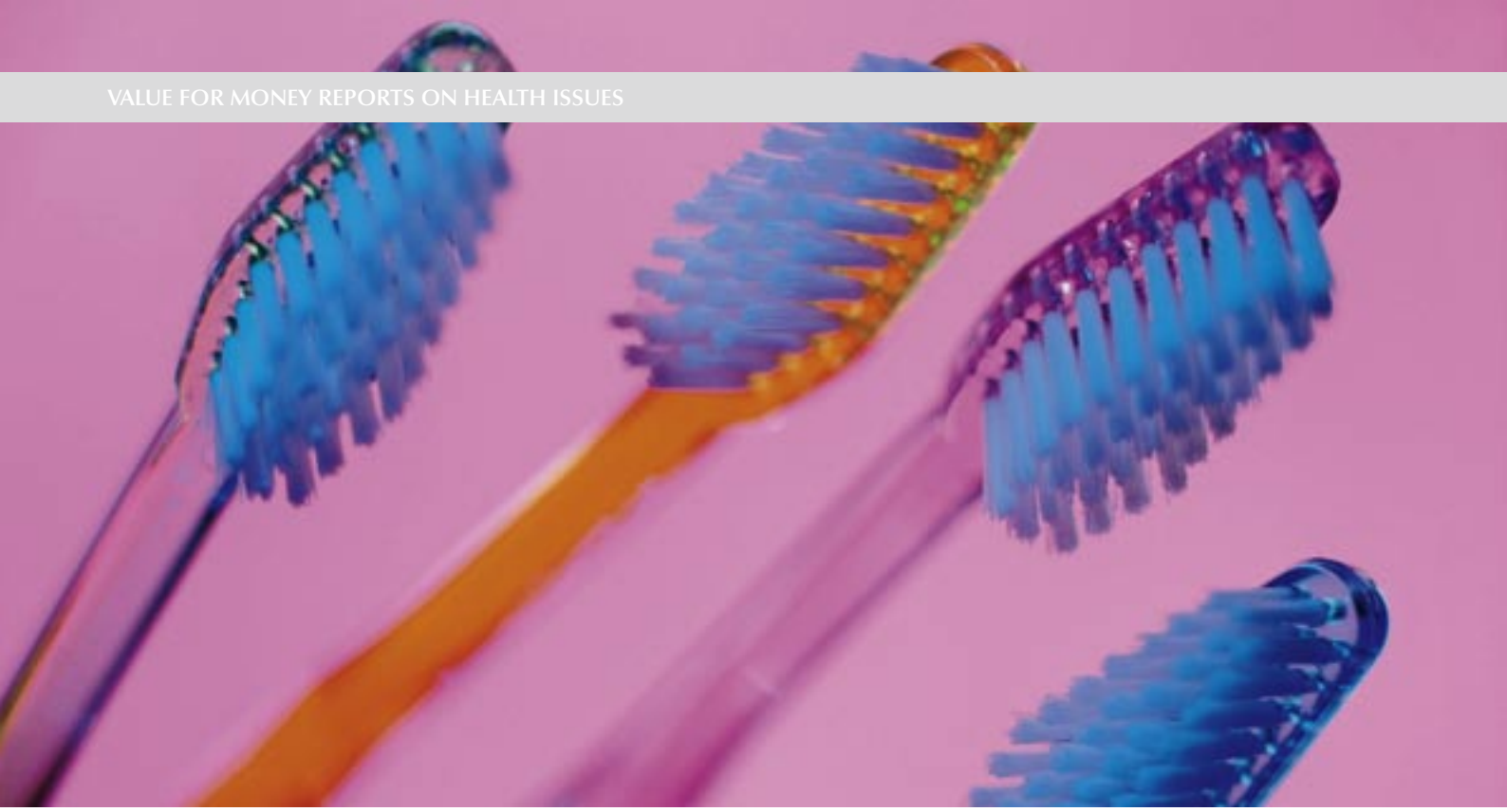
The report found that NHS trusts have achieved a large and sustained reduction in the length of time patients spend in A&E departments, largely through improved working practices. However, there is room for further improvement, particularly for patients with more complex needs (who include many older people and those with mental health needs) who are more likely than others to stay more than four hours in A&E. Patients' responses to the new open-access minor injury and illness providers, such as the 81 NHS Walk-in Centres, have been generally positive and attendances continue to rise. However, these services are mainly addressing previously unmet need rather than reducing demand on A&E. The relative cost-effectiveness of the alternative emergency care providers has not been established.

More than 50% of trusts had shortfalls in the numbers of emergency care medical staff needed to provide a robust and responsive service 24 hours a day, seven days a week. In some cases, the design of A&E buildings is not flexible enough to fit well with modernised working practices and to promote a more efficient, patient-orientated environment. As a means of securing the necessary integration of services, Emergency Care Networks are a promising development, though many are in their infancy and lack the authority and funding to bring about co-operation across the various emergency care providers.

The Committee of Public Accounts report's recommendations include:

- The Department should clarify the methodology for computing costs so that strategic planners for emergency care services can estimate the relative unit costs of the different providers and assess the impact on existing organisations if changes in service provision are made. Emergency Care Networks should be given responsibility for reviewing local patterns of demand compared to supply and emergency care services should be commissioned accordingly.
- The Department should make data available to all emergency care providers so that they can benchmark their performance and monitor their processes to ensure that older and more vulnerable patients spend no more time in A&E than is clinically necessary. In collaboration with other National Directors, particularly the Older People's Czar, the National Director for Emergency Access should promote action to identify ways of reducing the need for crisis emergency care for the elderly and those with mental health problems.
- To reduce variations in patients' experience of A&E services, NHS acute trusts should draw on approaches used by the highest performing departments and hospitals. These include widening staff responsibility for initial interpretation of x-rays, using up-to-date equipment in diagnostic services and making use of Departmental checklists for bed management and access to specialist opinion.


Self Care
Accident & Emergency
Pharmacist
NHS Direct Online
NHS Walk-in Centre
NHS Direct
GP's Surgery



NHS DENTISTRY

Reforming NHS Dentistry: ensuring effective management of risks
(November 2004)

Most of the 23,000 dentists in England provide both NHS and private dentistry services, but over the last ten years there has been an increase in the number of patients experiencing difficulties in accessing NHS dentistry, as many dentists reduced their commitment to the NHS and developed their private work.

In 2003-04 total expenditure on dentistry in England was some £3.8 billion, of which £2.3 billion was accounted for by the NHS and an estimated £1.5 billion by private dentistry. The NHS recovered £0.5 billion of this expenditure from patient charges. For more than a decade there has been pressure for reform of the dental remuneration system, in which dentists are paid per item of treatment provided, mainly because it has tended to encourage intervention, rather than prevention as favoured by modern dentistry.

In 2003 major changes were announced in which Primary Care Trusts will be responsible for commissioning NHS dental services in response to local needs, including having more influence over where dental practices are located and a simplified patient charge regime. The Department set an April 2005 target date for implementation, subsequently deferred until October 2005. Our study acknowledged that there is a strong rationale for modernising NHS Dentistry but there are significant risks that will need to be managed if the new arrangements are to be effective and provide value for money. In light of our report, the Department have acknowledged that they need even more time to implement the new contracting arrangements and have delayed their introduction to April 2006. They are also providing new guidance and additional support for Primary Care Trusts.

The Committee of Public Accounts report's recommendations include:

- The Department will need to pay very close attention to the results of their consultation on dental charging if they are to emerge with a system which commands the assent of all parties. The Department will also need to consider how to mitigate the risk that the changes in the charging system could create incentives for dentists to offer private treatment to patients at a lower cost than the NHS charge leading to a fall in the income that the NHS can recoup from patient charges.
- Even in more affluent areas patients may experience difficulties registering for NHS treatments as dentists have reduced their commitment to NHS dentistry. If they are to commission dental services effectively, Strategic Health Authorities and Primary Care Trusts need to improve their understanding of both need and demand for local NHS dental services through modelling the requirements of their local health economies.

PATIENT CHOICE

Patient Choice at the Point of GP Referral (January 2005)

The Department of Health has set the target that, by December 2005, each NHS patient referred by their GP to hospital for non-emergency treatment will be able to choose between four or five hospital providers. Under this system, patients will be able to choose from both NHS and independent sector providers. Key issues for the implementation of this target including the engagement of GPs and the rolling out of the Choose and Book information technology delivery system.

The report found that progress has been made towards delivering choice at referral through establishing the required organisational infrastructure, commissioning new IT systems and modifying exitsting ones and providing support for the NHS organisations that will deliver it. However, there is a risk that staff in the health service, particluarly GPs, are not fully engaged with the programme. The Department has an engagement plan to address these concerns. Choice is best delivered through electronic booking, although this will not be available to all patients by the target date of December 2005. The Department is taking steps to ensure that all patients will be able to choose their provider by the target date, and that the electronic booking system is put into place as soon as possible.

The NAO report's recommendations include:

- The Department should press on urgently with its plans for informing GPs about the implementation of choice at referral and its impact on GPs and patients; and
- The Department should keep under regular and close review the progress of its planned implementation of choice through implementing e-booking and consider the scope for accelerating the roll-out of e-booking to make it available everywhere by December 2005.

IMPROVING THE PATIENT JOURNEY

Tackling Cancer: Improving the Patient Journey (February 2005)

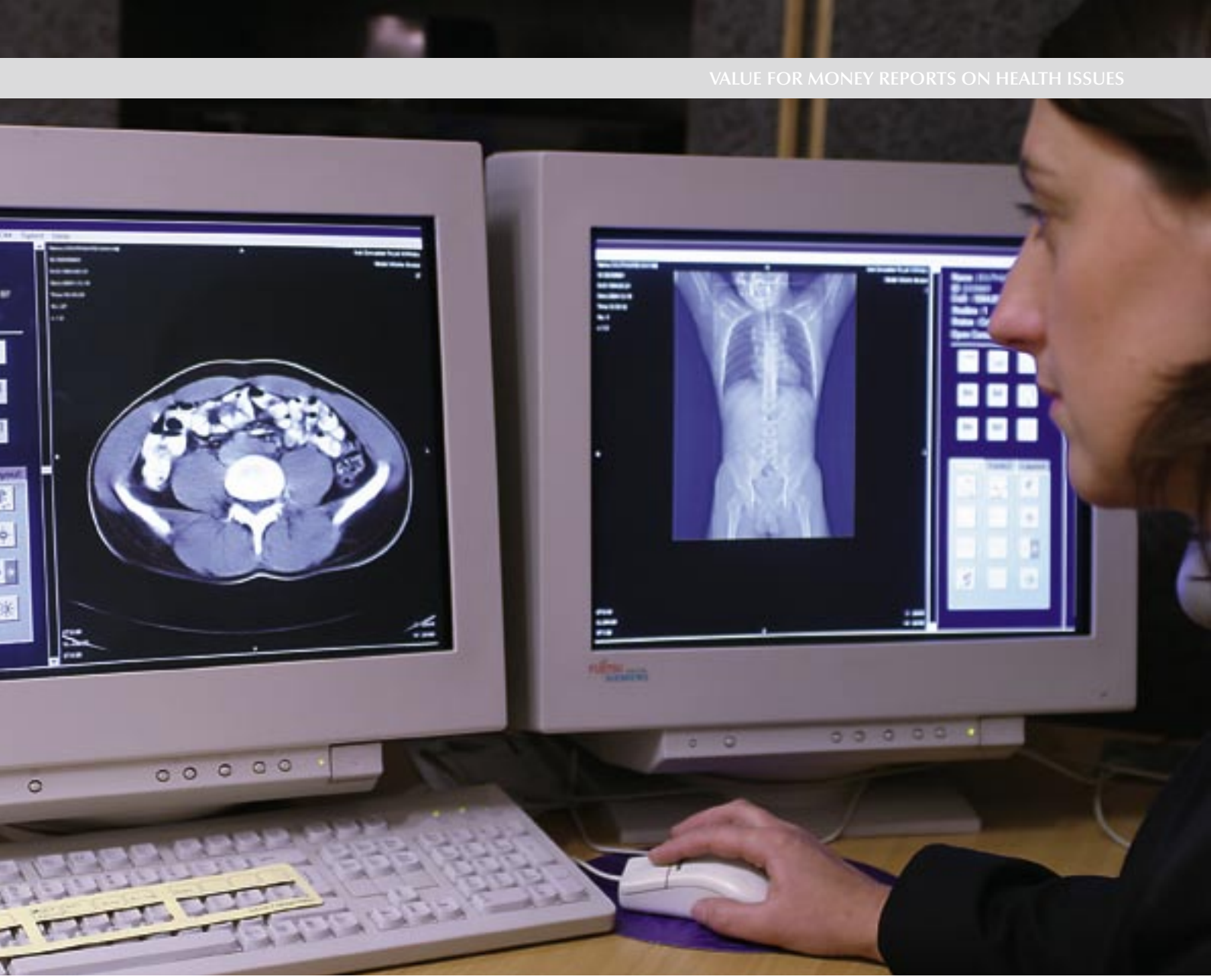
Patients' experiences of cancer services in England in 2004 have broadly improved on the situation in 2000, when the NHS Cancer Plan was introduced. In a survey carried out by the NAO, covering the patient journey from first appointment with their GP through to support in the community following hospital discharge, cancer patients were more positive about cancer services than those responding to a similar survey in 2000.

Overall, the report found encouraging progress had been made in most respects of the patient experience. However, for a minority of patients, the following elements of the patient experience were still not as good as they might be: communicating information, symptom relief, links to self-help and support groups and the lack of options for some patients in their last days.

Despite the generally positive results, certain groups of patients were less satisfied than others, notably patients in London and those with prostate cancer.

The NAO report's recommendations include:

- The Department should ensure that all parts of the NHS have robust plans for the implementation of best practice guidance in cancer patient care in three years.



THE NHS CANCER PLAN

Department of Health: The NHS Cancer Plan - A Progress Report (March 2005)

Our report found that the NHS Cancer Plan, published in September 2000, is broadly comprehensive, impressive in its coverage, and well regarded by cancer networks, the organisations established to bring together all local cancer services. There are ways in which the strategy for tackling cancer in England could be improved, however, and decisions need to be taken now on how to update and bring together all elements of the current cancer strategy in a unified way that ensures it remains the central guiding approach for improving cancer services and outcomes.

The NAO report's recommendations include:

- That the National Cancer Director should continue to consider what changes are necessary to the cancer strategy and that the Department should publish progress against key cancer outcomes;
- That the Department ensures that the roles of cancer network constituent organisations are clearly defined and adhered to;
- That Strategic Health Authorities should ensure that cancer networks have the necessary resources required for an effective and sustainable performance; and
- Cancer networks should have appropriate planning arrangements in place.

INNOVATION IN THE NHS

Department of Health Innovation in the NHS: Local Improvement Finance Trusts (May 2005)

Although 90 per cent of patient contact with the NHS is for primary care services, investment in primary care has historically been inadequate and piecemeal. Most public sector health investment has been channelled into hospitals. As a result, the quality of primary care buildings is often poor. To address these issues, the Department of Health announced in 2000 a major new initiative – the establishment of NHS Local Improvement Finance Trusts (LIFT) to develop primary and social care services and facilities in England. Our examination addressed whether LIFT is a suitable programme to support improved community-based health services that meet local needs while providing value for money. The report is very positive about the benefits of the innovative structure of LIFT - particularly the requirement that projects are agreed in the context of a local strategic plan and the flexibility it allows – but goes on to call for strengthening of accountability and performance measurement frameworks.

The NAO report's recommendations include:

- When planning a new initiative, a systematic approach to evaluating advisory firms and the quality of contributions from individual advisors should be established. This would help achieve good quality advice and value for money.
- Effective reviews of Strategic Service Development Plans for LIFT schemes should be undertaken regularly, in accordance with Partnerships for Health guidance.
- Guidance about the initiative aimed specifically at key groups of stakeholders (in the case of LIFT – clinicians, Local Authorities, Primary Care Trust senior management and secondary and acute care colleagues) should be developed and disseminated.
- In the light of experience, it now seems that the accountability framework of LIFT could usefully be strengthened. It would be beneficial for the Department to establish principles and develop guidance defining responsibility for local oversight of the Strategic Partnering Board.

NHS FINANCES

Financial Management in the NHS (June 2005)

Our joint report with the Audit Commission found that that the Department of Health achieved financial balance across the 600 local bodies of the NHS in 2003-04. However, compared with 2002-03, the number of bodies failing to achieve financial balance increased and there was also an increase in the number of bodies incurring significant deficits. The forecast position for 2004-05 is that there will be more NHS bodies facing a deficit, with the NHS as a whole not breaking even.

The report considers four key themes for improving financial management: the role of the Board, better and earlier forecasting of the financial position, earlier preparation and audit of accounts, and the need for greater transparency of the use of non-recurrent funding.

The role of the Board is particularly crucial as the report considers a number of recent examples of bodies incurring significant deficits and the consequences of ineffective oversight or lack of financial acumen at Board level.

The NAO report's recommendations include:

- The NHS Appointments Commission appoint individuals so that all Boards include non-executives with the appropriate financial management skills and experience;
- Board members take collective responsibility for financial matters and are able to understand, effectively challenge and act on the financial information presented to them;
- Finance Directors and Chief Executives present the Board with focused and timely financial information, clearly showing the overall financial position and highlighting the important issues that require action at Board level; and
- Where a body incurs a deficit, the Board should satisfy itself that the reasons for the financial difficulties are understood and that a realistic recovery plan is in place which tackles the difficulties, and should monitor progress against the recovery plan.

The report also briefly considers future developments. 2003-04 was a relatively stable year in terms of challenges facing NHS financial management but, despite this, a number of bodies found it difficult to manage resources effectively. Reforms in the NHS mean that there will be increasing financial challenges which bodies will be expected to manage. Primary Care Trusts and NHS Trusts will need to further improve their skills around the strategic aspects of financial management to cope with financial forecasting and modelling under Payment by Results, in particular the identification and management of the new risks that the system will bring. Increased use of independent healthcare providers will further intensify the uncertainty about income levels and highlight the need for better financial management. NHS Trusts will also need to develop appropriate commercial finance skills to be in a sound position to apply for Foundation Trust status.

NORFOLK & NORWICH PFI HOSPITAL

The Refinancing of the Norfolk & Norwich PFI Hospital (June 2005)

This was one of the first PFI hospital contracts when it was let in early 1998. The private sector consortium Octagon refinanced the PFI contract in 2003 which led to financial gains of £116 million in net present value terms. Octagon shared with the Trust £34 million, around 30 per cent of the gains, under the refinancing code for early PFI deals which the Treasury had agreed with the private sector.

The NAO report considered whether the gains accruing to the private sector from the refinancing indicated the Trust could have improved the original PFI deal and how the price the Trust is paying for the deal following the refinancing compares with current PFI hospital deals.

The report concluded that the terms of the original bank finance appear in line with other early PFI deals but subsequent improvements in PFI financing terms mean that the NHS Trust continues to pay a premium on the financing costs compared to current deals. There are other factors which may affect the overall comparison of the Trust's deal with current PFI deals including the fact that the benefits of a new hospital have been received earlier than in many other communities and the high rates of recent construction cost inflation have been avoided. It might have been possible for the Trust to have improved the original deal with greater competition and better defined requirements in the closing stages but the Trust is not convinced this would have brought added benefits as it sought to close a pathfinder deal which had already been assessed as providing value for money.

Key lessons of the NAO report include:

- Refinancing proposals involving increased termination liabilities or contract amendments such as extensions to the contract period should, in line with Treasury guidance, be subject to a rigorous value for money analysis before reaching a decision on whether to accept the proposals. Proposals to increase termination liabilities should be tested against alternatives involving no increase in contract termination liabilities;
- The Department should identify the effect that different factors are having on the pricing of PFI hospital deals over time. This analysis of pricing movements will be helpful to the assessment of bids for new deals and the evaluation of the progress of the PFI hospital programme. The analysis should include identifying the effect on the pricing of PFI deals of changes in:
  - The nature of deals being entered into;
  - General economic factors such as construction cost inflation and commercial borrowing rates;
  - Factors specific to the PFI market such as improved PFI financing terms and any cost efficiencies from the increased experience of the private sector in delivering PFI projects.

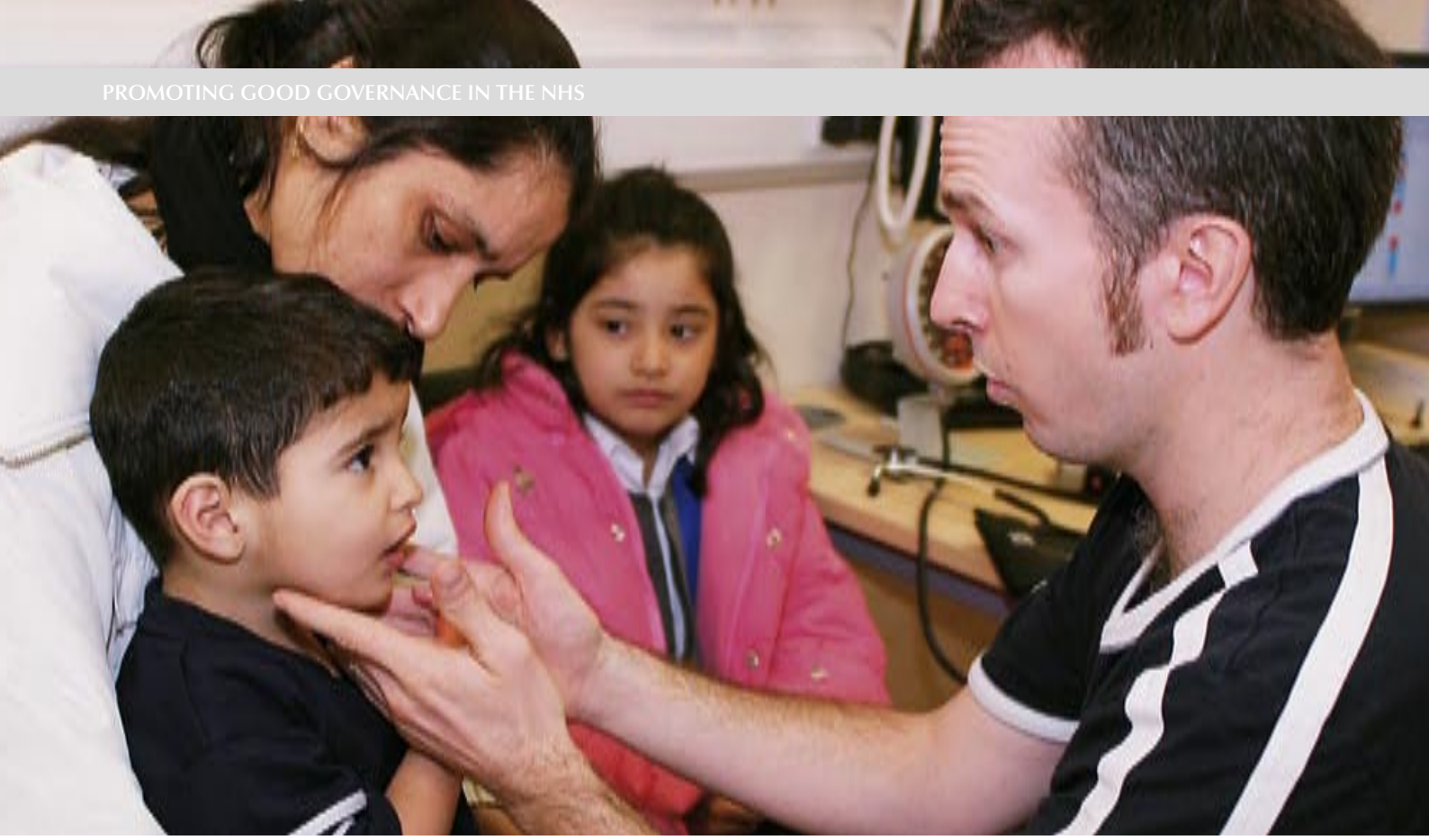
FORTHCOMING REPORTS

We are planning to publish a number of further studies in the very near future:

- **Organisational learning to improve patient safety,** which focuses on the quality of the NHS' strategy for ensuring that lessons are learnt from all relevant patient safety incidents at both local and national level and the progress that the NHS is making towards implementing the strategy (to be published Autumn 2005).
- **National Programme for IT in the National Health Service,** which examines the procurement processes used for placing the contracts; whether contracts are likely to deliver good value for money; how the Department is implementing the Programme, and the progress made by the Programme so far (to be published Autumn 2005).
- **PFI hospitals,** which will evaluate the performance of the 18 first wave acute PFI hospitals against contract and user needs, and will also draw out lessons learned and good practice for later wave schemes (to be published Autumn 2005).
- **Stroke Care in England,** which examines whether the quality of stroke services measure up against the costs of the illness. It identifies the critical barriers to receiving acute treatment and to preventing strokes, with particular attention to the many services and providers involved. Good practice and benchmarking also highlight the potential to improve the effectiveness, economy and efficiency with which stroke care services are delivered (to be published late 2005).
- **Out of Hours Services** will look at how the recent changes in Out of Hours services were implemented and examine the costs and performance of the new arrangements. It will also identify areas of good practice where Primary Care Trusts are innovating in order to create more patient-focused and integrated services (to be published early 2006).
- **The use of bank and agency nurses in the NHS,** which will focus on whether the NHS is managing its use of bank and agency nurses in the most economic and effective manner, covering both planning, procurement and deployment of temporary staff and whether the way cover is arranged risks undermining the quality of patient care (to be published Spring 2006).
- **Improving Quality and Safety: Progress in Implementing Clinical Governance in Primary Care** will examine whether patient care and patient experiences have been improved through implementing the clinical governance initiative in Primary Care Trusts. The study will: review the arrangements in place to help ensure effective strategic management of clinical governance; evaluate whether Primary Care Trusts are informed about progress in implementation of clinical governance; and identify whether Trusts are achieving improvements in the patient experience and the quality of care delivered to patients (to be published Spring 2006).

Further details of our forthcoming studies can be found on our website at **http://www.nao.org.uk/publications/workinprogress/wipindex.asp**. These reports will be made available online when they are published and you will be sent a copy for your interest.

For a number of these studies, we will be requesting your assistance in providing evidence for our report. We expect to send out surveys and questionnaires over the coming months on subjects such as out of hours services, Primary Care Trust clinical governance and temporary staffing arrangements. Mindful of the need to reduce the audit burden and aware of our responsibilities under the concordat, we are working hard to avoid duplication of other audit and inspection bodies and to ask only for information that is absolutely vital to our work. In return for your cooperation, we will ensure that you will be provided with important benchmark data and other outputs to help improve the quality of service provision.



WHAT ELSE?

While the publication of our value for money reports forms the core of our work, it is by no means all we do. You may have seen us speak at conferences on topics such as cancer care or hospital acquired infection. As follow-up work to our published report on Dentistry and our forthcoming report on Stroke Care we plan to organise conferences on these topics for January and February 2006. This will give us an opportunity to take our work forward into practical solutions for NHS organisations. You may also have received one of our detailed individual feedback reports following 'A Safer Place to Work,' a study of health and safety in the NHS and we will be providing similar reports for our study on patient safety. Some of our work may be less visible but nevertheless has great impact on the running of the NHS or individual trusts. Here we highlight one of these strands of work:

Promoting Good Governance in the NHS

In 2000, the NAO was asked to chair an efficiency review at the main Northern Ireland Teaching Hospital in Belfast. Following this, in 2002, the Leeds Teaching Hospitals Trust heard of the work and asked us to lead a similar process in Leeds, the biggest Trust in the NHS. We have recently started a similar process in central Manchester, working with the Trust, Primary Care Trusts and Strategic Health Authority.

Our role is to support the NHS Trust in benchmarking its activities and then, by challenge, to work with the Trust to develop robust action and savings plans, providing independent assurance on the Trust's progress to a Steering Group of key stakeholders. We do not set savings targets but we help the Trust deliver savings by providing an objective view and identifying risks to progress. In Manchester we have extended this role to cover the evaluation of demand management in primary care and the affordability and impact of such schemes on the local health economy. The ultimate goal is the financial stability of the Trust through efficiency-based savings, while maintaining or improving the delivery of healthcare to patients. Through this work, we have developed a powerful model for bringing rigour and realism to Trusts' financial recovery plans. We make explicit the link between finance and performance. The process is not about just saving money, but about spending money more efficiently and using benchmarking and good practice to challenge underperformance. It also seeks to build stronger relationships between suspicious or even hostile partners in the local health economy.

Before carrying out any such work we secure top level support from the Department of Health and chief executives of the local health community and our role as independent scrutineer is agreed by all parties. In Belfast, the process delivered recurring financial savings of £5 million over four years and in Leeds it delivered £19 million over three years. We also helped to deliver significant cultural and management change arising from the benchmark-based challenge to performance.

Steering Group – Paddington Heath Campus Scheme: Report of the Steering Group

The projected costs of the Paddington Health Campus (PHC) scheme escalated from an estimated £360 million when the Outline Business Case was approved in 2000 to over £800 million in mid-2003. In late 2003 the Treasury requested an independent review of the process that led to the situation. At the same time the NAO received correspondence from an MP requesting an investigation of the escalating costs and overall management of the PHC.

A joint Steering group was set up to investigate consisting of representatives from the Department of Health, the lead Strategic Health Authority, the Treasury and the NAO. Their report (September 2004) found that there had been shortcomings in the way the Paddington Health Campus scheme was run, reflecting changing and inadequate governance arrangements, the absence of agreed affordability envelopes and insufficient funding for the Project Team. It made a number of recommendations on governance of the scheme; the identification of options; the establishment of an affordability envelope; the development of models of care; and having a single client for the scheme. A new Outline Business Case was to be prepared by Christmas 2004.

The PHC scheme was cancelled by the North West London Strategic Health Authority in June 2005 after the NHS Trusts involved could not agree on the way forward.

Other Reports

We have also recently produced a range of reports that may be of interest to health professionals, on issues such as working with the Third Sector, citizen redress, homelessness and delivering public services to a diverse society.

Full details of these reports and others can be found at: **http://www.nao.org.uk**.

NAO PFI WORKSHOPS

The NAO is able to make available the following workshops which enable PFI project teams to explore further PFI issues relevant to their projects:

- **Managing PFI relationships to achieve success** – a one day workshop, focussing on relationship issues between public authorities and their PFI contractors. This workshop, which has already been attended by a number of NHS Trusts, includes presentations from projects in their operational phase and an expert on building business relationships.
- **PFI/PPP financing** – understanding the key issues – a one day workshop explaining the different types of private finance and issues which the public sector need to focus on. Refinancing and other current financing developments will be covered during the workshop.
- **PFI : Senior management briefing** – a half day workshop for senior officials, particularly those who may be new to PFI, giving an overview of the important issues which senior management need to be aware of when their organisations are embarking on a PFI project.

Each workshop is normally run exclusively for one individual project team to enable that team to maximise the opportunities to discuss issues relevant to their project. The financing workshop may also be run from time to time for a group of officials drawn from different projects. The managing PFI relationships workshop is either run for the public sector side on their own or, as may be helpful once the project is operational, with the private sector side also in attendance. If interested, please contact David Finlay at: david.finlay@nao.gsi.gov.uk.

Helping the nation spend wisely

The National Audit Office scrutinises public spending on behalf of Parliament

The Comptroller and Auditor General, Sir John Bourn, is an officer of the House of Commons. He is the head of the National Audit Office, which employs some 800 staff. He, and the National Audit Office, are totally independent of the government. Sir John certifies the accounts of all government departments and a wide range of other public sector bodies, and he has statutory authority to report to Parliament on the economy, efficiency and effectiveness with which departments and other bodies have used their resources.

Our work saves the taxpayer millions of pounds every year; currently at least £8 for every £1 spent running the office.

One of the key elements of the National Audit Office's independence is our ability to decide our own work programme.

Contact details

The National Audit Office is always interested in hearing from people about our work. If you would like to discuss our work in more detail or have suggestions for future work, please contact:

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