The ROYAL HOSPITALS

NIAO

Financial Auditing and Reporting: 2003 – 04 and 2004 - 05

Combined General Report on the Health Sector by the Comptroller and Auditor General for Northern Ireland

NIA 66/06 – 07

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N I A O
Northern Ireland Audit Office

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J M Dowdall CB Northern Ireland Audit Office

Comptroller and Auditor General 5th July 2007

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ABBREVIATIONS

CBI	Confederation of British Industry
CFU	Counter Fraud Unit
CRL	Capital Resource Limit
CSA	Central Services Agency
CTF	Charitable Trust Fund
DHSSPS	Department of Health, Social Services and Public Safety
EFL	External Financing Limit
EPES	Electronic Prescribing & Eligibility System
EWTD	European Working Time Directive
FPS	Family Practitioner Services
FReM	Financial Reporting Manual
GMS	General Medical Services
GP	General Practitioner
HPSS	Health & Personal Social Services
HSS	Health & Social Services
ICT	Information & Communications Technology
LCI	Lower Confidence Interval
NHS	National Health Service
NIAS	NI Ambulance Service
PFI	Private Finance Initiative
RPA	Review of Public Administration
RQIA	Regulation, Quality & Improvement Authority
RSS	Regional Supplies Service
SIB	Strategic Investment Board
SIC	Statement on Internal Control
SLA	Service Level Agreement
UCI	Upper Confidence Interval
VFM	Value for Money
WGA	Whole of Government Accounts

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Section 1 Introduction

1.1 Background

1.1.1 The financial audit of the accounts of the bodies comprising the Health and Personal Social Services (HPSS) in Northern Ireland was, until 31 March 2003, the responsibility of the Department of Health, Social Services and Public Safety (DHSSPS). In the years running up to this date, this audit was carried out by the Department's Directorate of Health Services Audit, which commissioned private sector accountancy firms to do the work on its behalf.

1.1.2 The Audit and Accountability (Northern Ireland) Order 2003, gave responsibility for the audit of health bodies to the Comptroller and Auditor General for Northern Ireland (C&AG) from 1 April 2003. This report deals with issues arising from the audit of the 2003-04 and 2004-05 accounts. It is the first of what will, in future, be an annual report, reporting on a single year's accounts. The report on the 2005-06 accounts is planned to be published by the Summer of 2007.

1.2 The Scope of the Audit and of this Report

1.2.1 This report covers the audit of 28 health bodies in 2003-04 and 29 health bodies in 2004-05. These include all Health and Social Services Boards (the Boards), all Health and Social Services Trusts (the Trusts) and a number of Agencies and Special Agencies set up by the Department (the Agencies). The results of the audit of the Department of Health, Social Services and Public Safety, and of the one Executive Agency and some Non-Departmental Public Bodies sponsored directly by the Department are reported elsewhere. A full list of bodies covered and those not covered by this report is shown in Figure 1.

1.2.2 A high proportion of health service audit work is contracted out to the private sector. However, the work is done to Audit Office standards and the certificates to the accounts are signed by the Comptroller and Auditor General. Tight control of the process is maintained by approving the plans of contractor firms, ensuring that progress is regularly monitored by Northern Ireland Audit Office staff throughout the audits, and by reviewing the work undertaken by the firms prior to the C&AG's sign-off.

Figure 1:

Bodies in the Health Sector Covered by this Report	
Trusts Altnagelvin Hospitals Trust Armagh & Dungannon Trust Belfast City Hospital Trust Causeway Trust Craigavon Area Hospitals Group Trust Craigavon & Banbridge Community Trust Down Lisburn Trust Foyle Trust Greenpark Trust Homefirst Community Trust Mater Infirmorum Trust Newry & Mourne Trust North & West Belfast Trust NI Ambulance Services Trust Royal Group of Hospitals & Dental Hospital Trust	South & East Belfast Trust Sperrin Lakeland Trust Ulster Community & Hospitals Trust United Hospitals Trust **Boards** Eastern Health & Social Services Board Northern Health & Social Services Board Southern Health & Social Services Board Western Health & Social Services Board **Agencies** NI Central Services Agency NI Blood Transfusion Service (Special Agency) NI Guardian Ad Litem Agency NI Health Promotion Agency NI Regional Medical Physics Agency NI Medical & Dental Training Agency (from 2004-05)
Bodies in the Health Sector Not Covered by this Report	
Department of Health, Social Services & Public Safety Health Estates Executive Agency Mental Health Commission for NI	NI Practice & Education Council for Nursing & Midwifery NI Social Care Council Regulation & Quality Improvement Authority (operational from 2005-06)

1.3 General View

1.3.1 I have been impressed by the steps being taken by both the Department and the HPSS itself, to raise the standards of controls and governance throughout the sector. However, whilst much progress has been made in some areas, further work is needed elsewhere, to ensure that control weaknesses are properly identified, and appropriate action taken. (See Section 4 for further detail.)

1.3.2 There are significant pressures on the Health services in Northern Ireland, which the Department puts down to the limited availability of funding to meet new initiatives and challenges, and the ever increasing expectations of patients, who naturally want to take advantage of improvements in medicines and technology. Comment is made on some of these pressures, later in the report.

1.3.3 Finally, the health services have had to prepare for major changes, particularly those arising from the Review of Public Administration which has had over recent months, and will continue to have for the next two or three years, a major impact on the administration of services. These changes will pose major challenges to the Department and the HPSS and comment is made on some of these and the developments arising from the Review, in Section 7.

Section 2 Monitoring of Financial Performance

2.1.1 Health & Personal Social Services (HPSS) bodies are required by the Department of Health, Social Services and Public Safety (the Department) to meet various targets each year and to disclose financial performance against those targets in their Annual Report and Accounts. Some of these targets are statutory and others are based on best practice.

2.1.2 The following paragraphs provide a general overview of the financial performance of health bodies for 2003-04 and 2004-05. Detailed financial performance data for individual bodies is noted in Appendices 2(a) and 2(b). The overall outcome on financial performance over this period was generally satisfactory, with a small number of exceptions.

2.2 Legislative performance measures

Break-even

2.2.1 Trusts are required by legislation[1] to ensure their income is sufficient to meet their expenditure taking one year with another. An explanation must be given in the accounts where variance from break-even in-year exceeds 0.5 per cent of the turnover of the reporting year. As part of the accountability process, the Department requires Agencies and Boards to conform to the general requirement of good financial management. Specific targets have been established for these bodies to breakeven on their income and expenditure account on an annual basis.

2.2.2 Where, during the course of any given year, potential deficits arise in Trusts, the Department has procedures in place whereby Trusts must develop contingency plans to restore in-year break-even. In 2003-04, only one Trust was in deficit (Sperrin Lakeland) and, although this deficit was reduced, it continued into 2004-05 when a second Trust (Mater Infirmorum) also incurred a deficit. The deficits in each instance were within the acceptable level of 0.5 per cent for break-even. For the Boards, the position in 2004-05 improved, with one of the two Boards able to turn around a significant deficit of £544k in 2003-04 into a surplus of £302k (Northern Board) and the other able to reduce its deficit by 20 per cent (Eastern Board). These figures include revenue and capital break-even. In both instances the original 2003-04 Board deficits were less than 0.1% of income. With regard to the HPSS Agencies, one had a deficit in

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

2003-04 (NI Guardian Ad Litem Agency) and one had a deficit in 2004-05 (NI Blood Transfusion Service). Further details on individual positions can be found in Appendix 2.

2.2.3 Break-even is measured by the Department before the impact of provisions is considered. If the break-even assessment were to incorporate provisions, six Trusts would have been in deficit in both 2003-04 and 2004-05, along with a seventh Trust and an Agency in 2004-05. The provisions causing these deficits are not funded centrally by the Department, and exclude clinical negligence provisions which are centrally funded. Nevertheless, there must be some concern that the current measurement of break-even does not reflect the true financial performance of the Trusts. In the National Health Service (NHS), not only is break-even considered after the impact of provisions, but it is also measured on a three–year rolling figure. This gives the NHS Trusts more flexibility in managing their provisions. The same flexibility does not apply in Northern Ireland due to slight variations in the budgeting regime, whereby both Departmental and HSS Trust break-even is measured on an annual basis only. The Department's view is that, if provisions had to be taken into account each year, this could result in major swings in spending plans arising unexpectedly in-year, which if tackled in-year, would impact directly on front-line services.

2.2.4 Legislation[2] states that Trusts are required to achieve financial objectives set by the Department. The Department requires disclosure of financial performance achieved against the following three targets:

Capital Cost Absorption Duty

2.2.5 HSS Trusts are required to absorb their capital costs annually at a rate of 3.5 per cent of average relevant net assets[3]. In 2003-04, nine of the Trusts fell outside the permitted materiality range of 3.0 per cent to 4.0 per cent and this increased to eleven Trusts in 2004-05. This may have been due to a number of different reasons, e.g. capital expenditure not occurring as planned, underestimation of depreciation, the introduction of the new Capital Accounting Manual referred to in paragraph 5.2.5. Trusts are encouraged to stay within their prescribed limits to reduce the likelihood of failure to break even as a result of having to pay additional public dividend capital payments or through under-charging.

[2] Article 15 (2) The Health and Personal Social Services (Northern Ireland) Order 1991
[3] Average relevant net assets – average of opening and closing net assets for the year

External Financing Limit (EFL)

2.2.6 Where finance generated by Trusts in the course of their operation is insufficient to fund all their activities, external finance may be required. EFL is a limit, set by the Department, on the amount of external finance that a Trust may access in any one year. It is an absolute financial duty, with a maximum tolerance of only 0.5 per cent of turnover under the agreed limit. Its purpose is to control the cash expenditure of the health sector as a whole to the level agreed by Parliament in the public expenditure control totals. When a Trust has a higher than average capital programme agreed, it will need to supplement its cash with further external borrowing (positive EFL) and conversely if it has a lower than average capital programme it will make net repayments (negative EFL). No Trusts breached their EFL in 2003-04 or 2004-05 although the Ulster Community & Hospitals Trust undershot (that is stayed within) its prescribed limit by a significant amount (£13.5m) in 2003-04 and the South & East Belfast Community Trust undershot its limit by almost £12m in 2004-05. These variances have been partially attributed to impairment charges being taken to reserves in line with Departmental guidance (see Appendix 2).

Capital Resource Limit (CRL)

2.2.7 The Department must live within a fixed annual capital spending limit voted by the Assembly / Parliament. The Department sets individual CRLs that translate the overall capital budget into spending limits applicable to each organisation. If the Trusts breach their CRLs, the Department's overall capital budget may be breached. In 2003-04 one Trust (Craigavon & Banbridge Community) breached its limit, but only by a negligible amount. Similarly, Armagh & Dungannon breached the limit by a negligible amount in 2004-05.

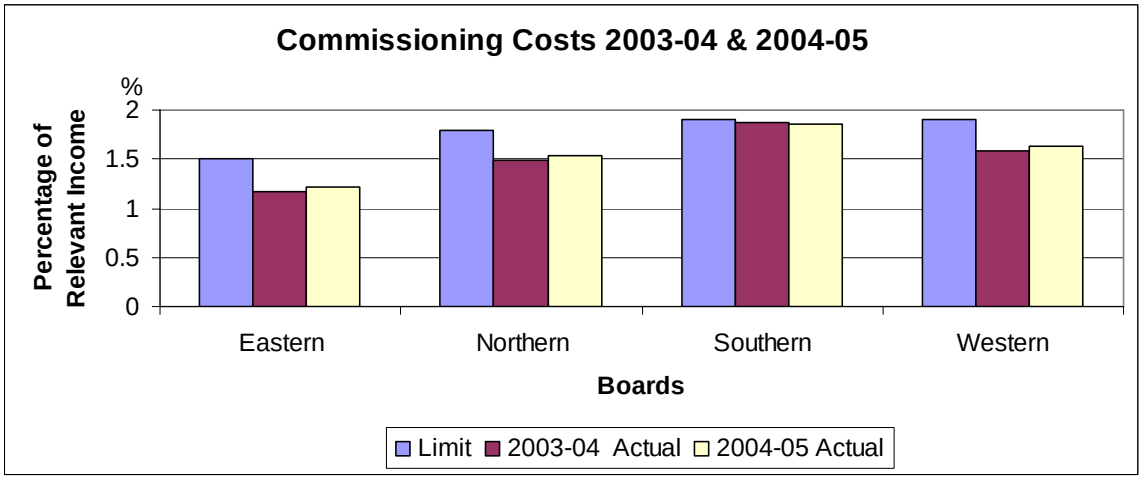
Commissioning costs

2.2.8 Legislation[4] also requires Boards to comply with directions by the Department to ensure that their affairs are conducted in such a manner as to prevent financial loss and to maintain efficiency. Boards are required to continue to manage their commissioning costs in the most efficient manner possible. Commissioning administration ceilings were set by the then Health and Social Services Executive in 1995-96 and these ceilings were still applicable for 2003-04 and 2004-05.

[4] Article 88 The Health and Personal Social Services (Northern Ireland) Order 1972

2.2.9 Boards are required to disclose their commissioning costs as a percentage of their relevant income, both figures being calculated in line with Departmental guidance, within their notes to the Accounts. Performance against target for 2003-04 and 2004-05 is noted in Figure 2.

Figure 2:



Source: DHSSPS Circulars and Board Accounts

2.2.10 All four Boards were within their commissioning targets, but the importance of continuing to manage costs as efficiently as possible, was reinforced by adjustments to these limits of 0.5 per cent and 1 per cent respectively over the following two years.

2.3 Best practice financial performance measures

Trust Management Costs

2.3.1 It is essential that HPSS resources are used efficiently, effectively and in the best interests of patients. Resources should not be diverted into unnecessary tiers of management and bureaucracy. Consequently Trusts are required to disclose their management costs in a note to the accounts. Calculation of these costs is based on the Audit Commission definition as detailed in Departmental guidance. In both 2003-04 and 2004-05, these costs were mainly between 3 per cent - 5 per cent of total income. Historically, Trusts were expected to manage their costs within 5 per cent of their income. Whilst the NI Ambulance Services Trust's costs were higher than the rest of the Trusts, at 6.4 per cent in 2003-04, this was reduced to 6.3 per cent in 2004-05.

Prompt Payment Policy

2.3.2 The Department requires that all HPSS bodies should pay their non–HPSS trade creditors in accordance with the Confederation of British Industry's (CBI) Prompt Payment Code and associated Government Accounting rules and disclose the extent to which they comply with these codes and rules. The 2003-04 and 2004-05 Accounts indicated that all the Trusts' and Agencies' payment policies were consistent with CBI prompt payment codes and Government Accounting rules.

2.3.3 Whilst no actual target has been set for compliance, best practice indicates a target of 95 per cent compliance in respect of both value and volume of payments. Performance in 2003-04 and 2004-05 is set out in Appendix 2(a) and 2(b) with the majority of bodies achieving 80 per cent or more. In value terms, although 2 Trusts were below 80 per cent in 2003-04, all bodies lifted their performance in 2004-05 above this level, although a number still failed to achieve the best practice targets. The Department has advised that it continuously monitors the reported prompt payment performance of HPSS bodies, and, where appropriate, writes to those Trusts with relatively poor compliance rates emphasising the need to achieve the target of 95 per cent compliance

Section 3 Audit Qualifications for 2003-04 & 2004-05

3.1 The review of the 2003-04 and 2004-05 accounts led to qualified opinions on the following :

- Central Services Agency 2003-04 and 2004-05 accounts;
- All 4 Board accounts for 2003-04 and 2004-05; and the
- Royal Group of Hospitals & Dental Hospital Trust Charitable Trust Funds accounts for both 2003-04 and 2004-05.

The key issues arising in each of these accounts is summarised below. The qualification on the Boards' accounts has also led to a qualification on the DHSSPS Resource Account for each of the years covered. I have commented on this in my General Report on financial audit work on the 2003-04 accounts[5].

3.2 Central Services Agency Qualification (2003-04 Accounts)

3.2.1 Although a substantial amount of audit fieldwork was undertaken in an attempt to reach an opinion on the 2003-04 financial statements, all the information and explanations considered necessary for the purposes of reaching an audit opinion were not available. I therefore disclaimed both the financial and regularity opinions.

3.2.2 No evidence of fraud or misappropriation of funds was identified during the course of the audit, and the accounts, as presented, did appear to break even.

Central Services Agency – Issues

3.2.3 The most significant issues arising were the deficiencies in the general ledger and the financial reporting function. The internal structure of the general ledger was a particular problem since the Agency prepared the accounts of three other bodies as well as its own. Throughout 2003-04, the general ledger had not been adequately maintained nor did it balance. This was adjusted by posting a £52 million one-sided journal entry and a subsequent journal to debtors and creditors to update the ledger for post audit journals reflected in the 2002-03 accounts. The absence of monthly monitoring of the balance sheet control accounts meant that such discrepancies were unlikely to have been detected and therefore reported

[5] Financial Auditing and Reporting 2003-04: General Report by the C & AG [HC 96] page 26, NIAO, July 2005

to management for corrective action. During the financial year 2003-04, the general ledger at no time reflected the correct position of the Agency. The structure of the ledger has since been updated to allow the CSA to better reflect the accounts of other bodies.

3.2.4 The audit trail required to prepare the financial statements for 2003-04 was also found to be unsatisfactory. The structure of the Agency's general ledger at the time was inadequate given the complexity of the business and its reporting requirements. The Agency's general ledger also records transactions for NI Guardian Ad Litem Agency, NI Social Care Council and NI Practice and Education Council. As separate account codes were not maintained for these bodies it was difficult to:

- disentangle transactions to produce separate balance sheets;
- demonstrate accurately the financial position of CSA;
- maintain appropriate financial control over CSA; and
- to identify, reconcile and agree inter-indebtness balances between the various bodies.

3.3 Central Services Agency Qualification (2004-05 Accounts)

3.3.1 In their response to the 2003-04 disclaimer, CSA put in place a number of processes and procedures to address the weaknesses identified. Consultants were engaged to carry out a review of the Agency's finance functions and considerable work was undertaken by Agency staff to generate an accurate set of accounts for the 2004-05 year. However, given the time taken to complete the 2003-04 audit process, these actions had little or no impact on the operation of internal financial controls during the 2004-05 financial year and it was evident that there were still serious weaknesses within the Agency's financial systems. Initial account drafts for 2004-05 were unsatisfactory and by January 2006, a fourth draft set of accounts was examined and found to be unacceptable. As a result, I disclaimed the 2004-05 accounts. The accounting transactions relating to the Family Practitioner Services and the Regional Supplies Service were considered adequate.

3.3.2 I strongly advised the Agency to ensure that the accounts presented for 2005-06 were thoroughly quality reviewed internally, before they were presented for audit. To this end, the Agency engaged consultants to quality review the accounts before they were submitted to NIAO. The audit of these accounts is still in progress.

3.4 Qualifications on the Health and Social Services Boards' Accounts for 2003-04 and 2004-05

3.4.1 Each Board's accounts were qualified again in respect of the estimated loss arising from inappropriate or fraudulent claims for Family Practitioner Services (FPS) Exemptions. FPS expenditure represents some 20 per cent of total revenue expenditure by Health and Social Services Boards.

3.4.2 Claims from practitioners in respect of these services are made to CSA which processes them on behalf of the Boards. Although the Boards are not directly responsible for the administration of this expenditure, they are, nonetheless, accountable for it. Service Level Agreements (SLAs) govern the arrangements between Boards and CSA.

3.4.3 As part of the SLAs, CSA perform a number of verification checks on the FPS payment processing. The work undertaken by CSA includes checks which produce information which provides the basis for the calculation of the estimated loss, deemed to arise through inappropriately or fraudulently claimed exemptions from the payment of statutory prescription and other charges.

3.4.4 The estimated loss for 2004-05 was calculated to be within a range from £8.2 million to £10.3 million. This represented an increase in the estimated loss after a period of several years in which a steady decline in the estimated loss had been reported. The Agency considered that this was a temporary dip arising from the nature of the sampling process itself and the loss did decline again in the following year. The counter fraud measures that have been put in place by both the Agency and the Department are discussed further in Section 6 of this report.

3.5 Royal Group of Hospitals & Dental Hospital Trust Charitable Trust Fund Qualification 2003-04 and 2004-05

3.5.1 I qualified my regularity opinion on the Charitable Trust Funds Accounts for the Royal Group of Hospitals and Dental Hospital Health and Social Service Trust for both 2003-04 and 2004-05. During the financial year 2004-05, Internal Audit identified twelve unauthorised bank accounts which were not captured within the system of internal controls and the accounting records of either the Trust's Public Funds or the Trust's Charitable Trust Funds. A number of these bank accounts were used for purposes which fall within the scope of the Trust's Charitable Trust Funds. (Also see paragraphs 5.3.9-5.3.11). My opinion on regularity was not qualified other than in relation to these transactions. My opinion on true

and fair presentation of transactions and balances in accordance with the accounting policies approved by the Department was not qualified in any respect as I am now satisfied that all material transactions operating through these bank accounts have now been captured.

3.5.2 At 31 March 2005, the net amount of funds in the bank accounts not captured within the Trust's accounting and internal control system was £142,000 (31 March 2004 - £146,000), reflecting a movement of £4,000.

Section 4 Governance Issues

4.1.1 Governance is the system by which an organisation directs and controls its functions and relates to its stakeholders. The board of each HPSS body has a duty on behalf of its stakeholders to ensure that the organisation is carrying out its responsibilities within a system of effective control and in line with Ministerial objectives. Assurance on this is given in the form of a Statement on Internal Control and is discussed below in sub–section 4.2.

4.1.2 The board must not only focus on financial and organisational governance but also on clinical and social care governance to ensure high quality health and social care is delivered. This section draws attention to the control assurance standards which are specific to HPSS bodies and to current developments in England that may impact on Northern Ireland concluding with governance issues that need to be addressed within the sector as a whole.

4.2 Statement on Internal Control

4.2.1 All public sector bodies should strive to develop and improve their internal control environment. They must make the most of the opportunity presented by the Statement on Internal Control (SIC) to assist interested parties in understanding:

- the risk and control issues facing the organisation, and
- how the organisation maintains and reviews the effectiveness of its internal control environment.

4.2.2 This enhanced transparency should ensure that risks are properly highlighted, prioritised and managed efficiently, effectively and economically, but it should also safeguard the organisation against potential serious incidents of a clinical / social care or of a more general nature.

4.2.3 In both 2003-04 and 2004-05, the SICs for the Public Funds Accounts complied with Departmental guidance and were appropriately enhanced where specific controls weaknesses were identified. However, in the majority of cases, the SICs prepared for these two years for the Charitable Trust Funds were not adequately tailored to reflect their particular system of internal control. This is a continuing issue and needs to be addressed by the relevant health bodies when drawing up their accounts for Charitable Trust Funds.

4.3 Controls assurance standards

4.3.1 In 2003, the Department introduced controls assurance standards, based on work carried out by the Controls Assurance Project in the NHS in England. These standards focus on key areas of risk within the HPSS and provide a vehicle for Accountable Officers to report the extent to which these risks are being effectively controlled. For 2003-04, six HPSS controls assurance standards were developed by the Department and formally issued. These covered:

- governance (core standard);
- financial management (core standard);
- risk management (core standard);
- human resources;
- medical equipment and devices; and
- medicines management.

4.3.2 The Department issued a further eight non-core standards for 2004-05. These covered:

- buildings, land, plant and non-medical equipment;
- decontamination of medical devices;
- environmental management;
- fire safety;
- health and safety;
- infection control;
- information and communication technology;
- waste management.

4.3.3 Health bodies are required to self assess and, following approval by the board, report their level of compliance with these standards to the Department. This information is also used by the Accounting Officer of the Department to support the SIC in the Departmental Resource Accounts.

Independent verification

4.3.4 Each year the Department advises the health bodies which standards require independent verification by Internal Audit or other means. In both 2003-04 and 2004-05 this included the three core standards, with independent verification required for an additional three non–core standards in 2004-05[6]. Independent verification of the reported levels of

[6] Decontamination of medical devices, fire safety and infection control.

compliance, including internal and external audit and review, is expected to be an ongoing process rather than a year end exercise.

4.3.5 Most HPSS bodies have commissioned their Internal Audit function (see paragraph 4.5) to carry out the independent verification process in conjunction with their other audit work on key financial systems within the organisation. This has given rise to a strain on resources culminating in the completion of the assurance work primarily at year end. With additional assurance standards introduced in subsequent years and the requirement for accounts to be produced and audited earlier, there is concern that reporting by Internal Audit may slip if not properly resourced. Health bodies must ensure that this essential control is adequately resourced to enable verification to be completed at the proper time.

4.3.6 There are also concerns in relation to the nature of the verification process and the expertise required to carry this out, particularly in areas of clinical governance. The verification process needs to be more than a check for the existence of particular control procedures. It must also cover how effective these control procedures have been in the management of risk. This is further illustrated in the examples below, which occurred during this period.

Case A: Sperrin Lakeland Trust

In early 2005, Sperrin Lakeland Trust commissioned the NHS Clinical Governance Support Team to carry out an effectiveness review of the Trust's clinical and social care governance arrangements including the extent to which the Trust's Clinical and Social Care Governance Strategy had been operational across all acute care specialities. A key finding that emerged from the Phase 1 report, issued in May 2005, was that risk management and governance arrangements were historically more focussed on non-clinical than clinical risk and the operational reality was that the governance arrangements in place were not sufficiently robust, with significant gaps in risk management existing at all levels of the Trust. Following the report's publication, the Trust, in conjunction with representatives from the Western Health Board, DHSSPS and the NHS Clinical Governance Support Group, began implementing the recommendations of the review, including changes in the senior management arrangements within it.

4.3.7 In their original self assessment, Sperrin Lakeland Trust's performance against governance and risk management standards was assessed by the Trust as being in line with expected levels. However, Internal Audit was unable to support these assessments and the scoring was not accepted by the Department. Furthermore, the findings emerging from the effectiveness review mentioned above also appeared to contradict the scoring. Consequently, the Trust withdrew their gradings against these standards and noted in their SIC that performance against these standards was undetermined. Their original self assessment indicated that control procedures were adequate. However, it did not appear to have considered how the controls were operating in practice. As part of additional assurance work undertaken, NIAO reported to the Department that the management arrangements within the Trust were not operating effectively throughout the year.

Case B: Central Services Agency

The details of the audit qualification in respect of the 2003-04 Accounts have been discussed in an earlier section (see paragraph 3.2). The Agency's Accountable Officer noted in the SIC that the system of internal control could not be regarded as wholly effective in all respects due to deficiencies in the system of internal financial control. As in Case A, the Agency's self assessment against the applicable standards indicated substantive compliance. Internal Audit initially supported the assessments; however in light of subsequent audit findings they revisited their verifications and concluded that compliance was not to the level previously determined, especially in respect of the Financial Management Standard. Consequently, the Agency embarked upon a plan of remedial action to address these deficiencies. As noted in paragraph 3.3, serious control weaknesses still existed in 2004-05 in part due to the delay in completing the 2003-04 audit. This has meant that actions taken more recently had little time to impact on the 2004-05 financial year and the 2004-05 accounts were also disclaimed. As in the case of Sperrin Lakeland Trust, NIAO advised the Department that the management arrangements within the Agency were not operating effectively during the year.

4.3.8 Some HPSS bodies have also engaged the services of experts to independently assess compliance with those assurance standards which require specialist knowledge such as infection control, decontamination of medical devices, medicines management and health and safety. The application of such an approach across the HPSS sector has not yet been evaluated, but action on these lines seems sensible.

4.3.9 High levels of compliance were achieved across the HPSS sector in both 2003-04 and 2004-05 and this is illustrated in the benchmarking information detailed in Appendices 1(a) and 1(b) and in Figures 3 and 4 below, summarising the position. The position of Central Services Agency and Sperrin Lakeland Trust has already been discussed above. All of the Trusts that did not meet expected compliance with certain standards in 2003-04 achieved the targeted levels of compliance in 2004-05. However, the Risk Management scores for one Trust, the Ulster Community & Hospitals Trust, and the Human Resources score for the NI Medical Dental Training Agency fell in 2004-05 and these bodies were advised to take the appropriate action to bring these scores back up again.

4.3.10 There was also a failure on the part of an Agency (the Health Promotion Agency) to achieve adequate independent verification of the assessment of compliance against core standards and any applicable non-core standards issued. This was a breach of Departmental requirements as set out in paragraph 4.3.4 above.

Figure 3:

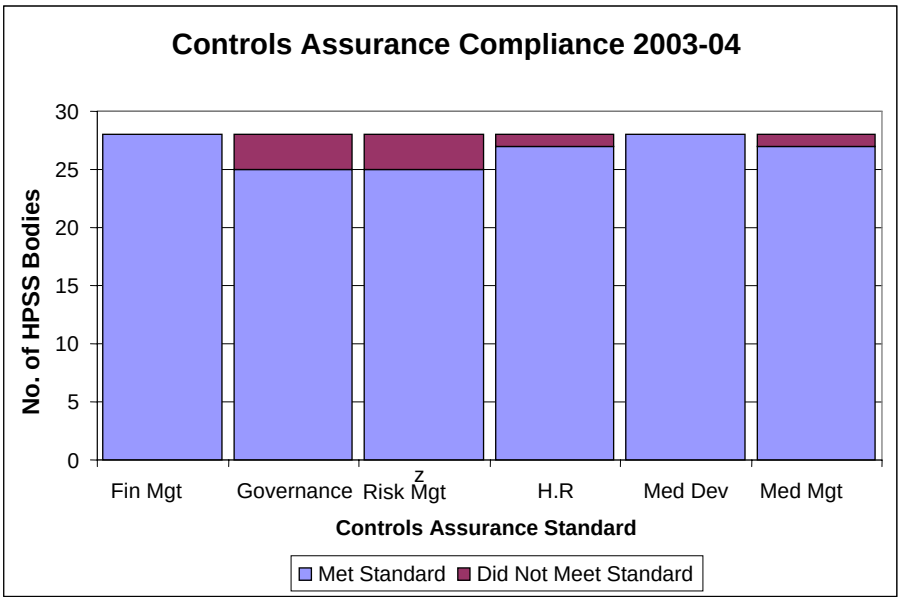
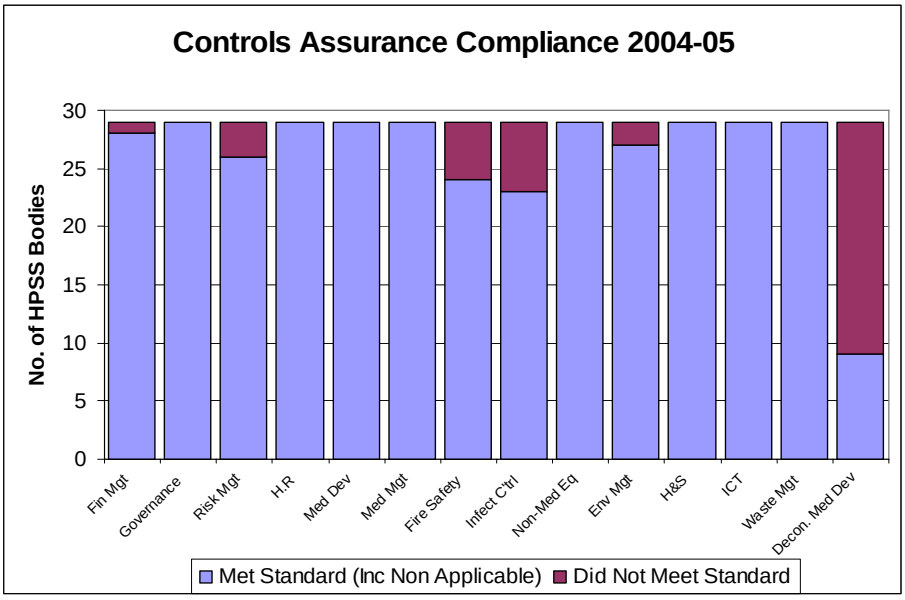


Figure 4:



4.4 Current Developments in Great Britain

4.4.1 From 1st August 2004, the controls assurance regime, currently being followed by HPSS bodies in Northern Ireland, has been terminated by the NHS, following the launch of the NHS Health and Social Care Standards

and Planning Framework. The basic justification for the change was that the risk management principles initially enshrined in the NHS standards had, by then, been firmly embedded in the management processes. However, as the controls assurance programme in Northern Ireland has not yet been fully rolled out, it is not considered to be embedded here.

4.4.2 Central to the new framework is the assessing and reporting of the performance of healthcare organisations through an annual health check, part of which includes performance against core and developmental standards. The core standards are based on the standards and requirements which already existed within the NHS whilst developmental standards are comprehensive, broad-based and framed to encourage continuous improvement over time. The health check also includes work to be undertaken by auditors on the use of resources. Based upon this work the Audit Commission generates an overall Auditors' Local Evaluation Score for each organisation**,** which feeds into the Healthcare Commission's overall performance assessment for the entity. In October 2006, the Commission published the results of its latest annual health check, wherein each NHS Trust in England was given a rating, based on the quality of its services and how well it managed its finances.

4.4.3 The current HPSS controls assurance programme in Northern Ireland has, given the range and complexity of the governance agenda, continued to evolve. The Regulation, Quality and Improvement Authority was established in April 2005 to assist in this purpose. This is discussed further in paragraphs 4.7.1 to 4.7.4.

4.5 Internal Audit

4.5.1 The purpose of Internal Audit is to provide assurance to management on the adequacy and effectiveness of the system of internal financial control. Functions performed by Internal Audit include the investigation of suspected fraud, the provision of advice in relation to governance issues, and an opinion on the adequacy of controls in new systems under development. As noted in paragraph 4.3.5, Internal Audit is often required to validate self assessments performed by various health bodies and may not have the requisite skills to fully perform this function. Such validation may require clinical experience, or expertise in a range of technical areas.

4.5.2 For 2003-04 and 2004-05, the HPSS bodies used four Internal Audit service providers which generally cover each Board Area respectively. An exception was the Health Promotion Agency, which used the Southern Area Internal Audit Service during that period. Health bodies are

permitted to appoint their own Internal Auditors and, as with any other function, are advised to regularly review the service with which they are provided, in terms of both quality and cost.

4.5.3 Internal Audit work is carried out in accordance with professional auditing standards and the Government Internal Audit Standards. NIAO have evaluated all four Internal Audit Units and I was able to place reliance upon their work during 2003-04 and 2004-05 and to take this into account when planning my own work.

4.5.4 The HPSS sector has been well ahead of Central Government in the development of Audit Committees which offer vital support to the Accountable Officer and board and this is a strength for which both health bodies and DHSSPS can take credit. With the implementation of faster closure of the accounts and audit processes, it is incumbent on health bodies (through their Audit Committees) to ensure that programmes of Internal Audit work are sufficiently resourced to permit Internal Audit work to be completed by the dates required, so that faster closure timetables (see paragraph 7.3.7) are not compromised.

4.6 Other governance issues

Senior Employees' Remuneration

4.6.1 Good practice says that senior individuals employed in a decision-taking position in the public sector, and who are paid from public funds, need to be completely open about the extent to which they are paid. Since 2003-04, HPSS bodies have been required to disclose Senior Employees' Remuneration[7] details in a note to their annual accounts. In specific terms, *Senior Employees* refers to the Chief Executive, executive directors and other functional directors who operate at board level within the respective organisations. For 2004-05, the disclosure requirements were amended slightly and HPSS bodies were then also required to disclose information for all their non–executive directors.

4.6.2 During this period, the disclosures in the note to the accounts could not, however, be given without prior consent from the individuals concerned. Consent could be obtained once, for all future periods, and for new appointees, it could be made a condition of appointment, but individuals in post could rely upon the Data Protection Act 1998 and withhold their

[7] The Department defines senior employees as 'those persons in senior positions having authority or responsibility for directing or controlling the major activities of the organisation'. (It relates to all those individuals who hold or who have held office as a senior employee at the organisation during the reporting period).

consent to disclose. Where this was the case, 'consent to disclosure withheld' was required to be stated in the accounts, along with a note of what information was withheld and by whom.

Actual Disclosure of Senior Employees Remuneration

4.6.3 In relation to the 2003-04 and 2004-05 accounts, the level of non-disclosure was, overall, disappointingly high although the Boards should be commended as three of them disclosed in full. In both 2003-04 and 2004-05, only two of the Agencies disclosed in full. There was a high degree of variation on the amount of information disclosed in the Trusts with a trend towards non-disclosure, although the position has improved since 2003-04. Details of actual disclosure for both 2003-04 and 2004-05 can be found in Appendices 3(a) and 3(b). Examples of the disparity in practice include:

- Foyle Trust, where the Chief Executive provided full disclosure but all other executive directors withheld consent in full in both 2003-04 and 2004-05;
- Homefirst Trust, where all executive directors withheld consent to disclose information, except for the Chief Executive who disclosed all salary and benefits in kind details in 2003-04; however the position improved considerably in 2004-05 with full disclosure by all executive and non–executive directors; and
- Ulster Community and Hospitals HSS Trust, where all senior employees disclosed details of salary in both 2003-04 and 2004-05 but withheld consent in relation to other information required except for the Chief Executive who disclosed in full in 2004-05.

4.6.4 Senior employees in the Royal Group of Hospitals Trust disclosed the remuneration information in full for 2003-04 and 2004-05. Furthermore, except in one of the Trusts, disclosures by non executive directors were made in full, which demonstrates their understanding of the need for openness and transparency in the public sector.

4.6.5 The actual levels of disclosure in the 2003-04 accounts led to the then Accounting Officer of DHSSPS formally writing to all Chairs of Boards, Trusts and Agencies, in November 2004, encouraging senior staff to give their consent for full disclosure in the 2004-05 and subsequent sets of annual accounts. Full disclosure has also been encouraged by the Financial Reporting Advisory Board, the Chair of which pressed the public sector to be at least as open as listed companies in its reporting of the remuneration packages of senior public servants.

4.6.6 All relevant members of the Senior Civil Service in England have now agreed to disclosure. Northern Ireland counterparts and senior employees within the HPSS sector are being encouraged to follow suit. In light of the considerable restructuring changes arising out of the Review of Public Administration (see section 7.2) the Department has made disclosure for relevant staff a specific requirement as a condition of new appointments, an action which the Cabinet Office is also planning to do elsewhere. A recent judicial decision has given health bodies the right to disclose information about the remuneration of their senior employees, and the impact of this change will be covered in my next report.

4.7 Way forward

4.7.1 Whilst there have been marked improvements in recent years, there are still some weaknesses in the governance framework as it currently exists within the health and personal social services in Northern Ireland, especially in respect of clinical and social care governance. The Department intends to address the majority of these weaknesses through its continuing programme of setting targets and monitoring performance and through the new Regulation, Quality and Improvement Authority (RQIA), whose role is set out in legislation.[8]

4.7.2 The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 introduced a statutory duty of quality which underpins the clinical and social care governance responsibilities of HPSS bodies. New high–level Quality Standards for Health and Social Care are to be introduced to support good governance and best practice. These Standards will provide a platform for RQIA to inspect and report on the quality of care and services commissioned or provided by HPSS bodies.

4.7.3 The Department is being proactive in this area and has recently issued guidance[9] to help boards meet their responsibilities for providing assurance. The guidance will be subject to review as decisions on restructuring of the HPSS take effect in the light of the Review of Public Administration. Section 1.7 of this guidance further emphasises the role of the RQIA:

[8] Established as the HPSS Regulation and Improvement Authority by Part IV of the HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003.
[9] Establishing an Assurance Framework: A Practical Guide for management boards of HPSS organisations

"the HPSS RQIA has a pivotal role to play in ensuring that integrated governance[10] processes are in place throughout the HPSS and that they provide to the public effective assurance that the services they rely on are appropriate, safe and of the highest quality. By monitoring and inspecting services, by examining the governance arrangements, by investigating particular events and reviewing actual practice, the RQIA will be able to reach a definitive view on the quality of service provision in the HPSS."

4.7.4 The Department expected the Authority to have embarked on a full programme of clinical and social governance reviews of HSS Boards and Trusts from 2006-07. In the preceding year, RQIA completed two commissioned reviews – one into the unexpected death of a patient at the Royal Group of Hospital Trust, and the other into the Northern Ireland Breast Screening Programme. It also inspected the child protection arrangements in Sperrin Lakeland Trust and Foyle Trust. This was in addition to its continuing programme of registration and inspection of statutory and independent residential and nursing homes[11].

[10] Integrated governance can be defined as 'systems and processes by which Trusts lead, direct and control their functions in order to achieve organisational objectives, safety, and quality of services, and in which they relate to the wider community and partner organisations.' NHS Confederation (May 2004).
[11] The Regulation and Quality Improvement Authority Annual Report & Accounts: 2005-06 (November 2006)

Section 5 Matters Arising During 2003-04 & 2004-05

5.1 This section refers to key issues that arose during the 2003-04 and 2004-05 audits. Issues arising are either general or technical accounting issues or refer to management arrangements, and are discussed within these headings below.

5.2 Accounting issues

Quality of Accounts

5.2.1 Generally, accounts presented were found to be of a good standard and this augurs well for the continuing challenges arising from:

(i) the faster closure of accounts to allow for the laying of accounts prior to the Parliamentary Summer Recess; and
(ii) the structural and accounting changes necessary as a result of the Review of Public Administration.

5.2.2 However, there were a few exceptions. There were delays in submission of some accounts, e.g. draft accounts due for submission for audit by one of the Agencies on 10 June 2005, were not submitted until 1 September 2005. A degree of carelessness in preparation of some draft accounts was also noted; an extreme example being one of the 2004-05 charitable trust fund accounts which had to be redrafted five times over a three month period before they were found to be of a satisfactory standard. The errors found in these draft accounts resulted in unnecessary additional audit costs being incurred against public funds.

5.2.3 The faster closure initiative is discussed further in section 7.3.

Inconsistency in Annual Reports

5.2.4 There is an element of inconsistency of practice amongst the Boards and Trusts regarding the content of their annual reports. This resulted in limited summary financial information being reported in certain cases. For example, the annual report for one of the Boards contained no balance sheet, limited detail on management costs and no details of compliance with the better payments practice code. Some bodies provide their readers with absolute minimal financial information, merely providing references to their websites on which annual accounts are placed. Other bodies provide very comprehensive financial information. Although the Department provided detailed guidance on the content of the Annual

Report, it gave the Boards and Trusts some flexibility regarding the inclusion of summary financial statements. This resulted in some lack of clarity which contributed to this inconsistency. The Department has since removed this flexibility. This took into account the additional disclosure requirements arising from the new Financial Reporting Manual (FReM)[12], which was ~~is~~ applicable from 2005-06. All HPSS bodies are now required to produce summary financial statements or full accounts within the Annual Report.

Capital Accounting and the Issue of Guidance by DHSSPS

5.2.5 In 2003-04, DHSSPS revised the Capital Accounting Manual which had not received a major overhaul since capital accounting had been introduced to the HPSS in the early 1990s. Consequently, the revision was welcome. However, the lateness in the financial year of the issue of the revised Manual proved to be a significant pressure on resources for the HPSS sector. There are often good reasons why it is not possible to time the issue of guidance earlier in the year (e.g. the Department may be unable to issue guidance prior to receiving other essential information from another source). However, it is essential that HPSS bodies be given guidance and directions affecting their accounting procedures as early as possible, if faster closure is to be achieved.

Provisions

5.2.6 In line with accounting guidance, HPSS bodies are required to provide for legal or constructive obligations that are of uncertain timing or amount at the balance sheet date. These provisions are calculated on the basis of the best estimate of expenditure required to settle the obligation.

5.2.7 As noted in paragraph 2.2.3, the Department measures the operating performance of HPSS bodies by reference to the operating surplus / deficit excluding the impact of certain provisions. However, I report on the retained surplus or deficit, which incorporates costs associated with these provisions.

5.2.8 A substantial element of the provisions figure is in respect of clinical negligence liability which is funded by the Department. However, there are other provisions, e.g. employer liability and public liability, which are not funded by the Department and these costs should be considered

[12] The FReM replaced the Northern Ireland Resource Accounting Manual for Departments and Agencies. Paragraph 1.13 of the FReM indicates that 'the Department of Health, ...and the Department of Health, Social Services and Public Safety for Northern Ireland will apply the principles outlined in the Manual to maintain the accounting guidance they issue in respect of Strategic Health Authorities....and Health and Social Services Trusts.

when assessing financial performance of these bodies (see paragraph 2.2.3).

5.2.9 Furthermore, restructuring provisions are currently not funded by the Department. With the implementation of the Review of Public Administration proposals, there are likely to be significant restructuring costs. Dependent on funding decisions, measurement of performance may not be meaningful if such costs are excluded.

5.2.10 The review of the 2003-04 and 2004-05 accounts revealed instances where Trusts:

- had inadequate procedures in place to capture all provisions (Mater, United);
- had not adequately provided for legal costs and fees of cases (Mater, South & East Belfast); and
- were not receiving timely /robust estimates of settlement / likelihood of settlement from their solicitors (Mater, United, Causeway, NI Ambulance Service, North & West Belfast).

Family Practitioner Services 2003-04 and 2004-05 Assurances

5.2.11 Assurance on Family Practitioner Services (FPS) expenditure is provided by the Central Services Agency (CSA) to the individual Boards, in line with their Service Level Agreements. This assurance is provided, along with the FPS figures**,** for inclusion in the Boards' accounts. An independent assessment of this assurance through audit work performed at the CSA is passed to NIAO. A number of management points and recommendations were made in relation to this expenditure during 2003-04. While these did not impact upon the assurance provided, it was disappointing to note that the process in place at the CSA for generating the year end expenditure and accrual figures could have been better organised, with more management input. Consequently, CSA management agreed to put in place a more formalised process to ensure that the weaknesses identified in 2003-04 did not recur.

5.2.12 Similar assurances were also provided for 2004-05. However, there was no evidence that there had been improvement in the process. Given the significance of these assurances to the Board Accounts, and ultimately the Departmental Resource Account into which the Board Accounts feed, it was imperative that early improvements should be made to these processes within the Agency, especially in view of faster closure.

5.3 Management arrangements

Regional Supplies Services 2003-04 and 2004-05 - Regularity Opinion

5.3.1 Central purchasing arrangements operate within the HPSS and all bodies are encouraged to make use of centrally negotiated contracts and regional purchasing expertise through the Regional Supplies Service (RSS) which is an integral part of the Central Services Agency. I am required to give an additional regularity opinion on RSS to all health bodies which utilise its services. A review of RSS processes and procedures, coupled with the testing of a sample of key transactions at RSS in both 2003-04 and 2004-05 indicated, with one exception, that RSS had substantively complied with the relevant legislation and regulations in respect of HPSS central purchasing transactions. The exception relates to supplies procured by way of a form CF61. This form is completed by the HPSS body, when a decision is made by the body to over-ride the DHSSPS Procurement Mini-Code. In these instances, no opinion on the regularity of expenditure could be formed. As such, the regularity opinion was qualified in respect of these transactions but was not qualified in all other regards. In 2004-05, CF61s constituted approximately 3 per cent, by value, of the procurement requisitions received by RSS.

5.3.2 Substantive testing of CF61s was undertaken at the various health bodies to ensure that the decision to override normal procurement practices was clearly documented, justifiable and properly approved at Chief Executive level. This testing did not identify any significant instances where expenditure could be regarded as irregular. However, it was noted that, in 2004-05:

- in two cases at one Trust (Causeway) clear explanations were not provided to support the action taken;
- one Trust (United) did not appear to have adequate records to support the level of CF61 expenditure of £451k; and
- one Trust (Down Lisburn) used 9 of its 26 CF61s raised in the year in the month of March and incurred expenditure of £209k.

Management of contract nursing staff and locum doctors

5.3.3 A prerequisite of the Government's modernisation programme for the NHS is the need for both adequate and experienced doctors and nurses to be employed by Trusts. Due to a shortage of these key staff within the Health Service, Trusts have had to employ locum doctors and nursing staff from agencies. Clearly, the associated high costs of such action, and potential risks to patient care must also be considered, but balanced

against the requirement by Trusts to ensure that patient care is continued at the appropriate level. The answer to a Parliamentary Question[13] in 2005 revealed that expenditure on temporary and locum staff in Northern Ireland had risen from £8.7m in 1999-2000 to £31m in 2003-04. The high costs being incurred by some Trusts is illustrated by the case of a locum consultant radiologist who was paid £240k for work during 2004-05, for which a permanent member of staff would have been paid approximately £71k. When the permanent post was advertised, the locum consultant did not apply.

5.3.4 Where staff are recruited from overseas, the recruitment costs must also be considered as well as the additional resources needed to devise and implement tailored induction programmes and training packages. For example, three senior staff from one Trust spent 16 days in the Philippines during 2002-03, recruiting overseas staff for a wide range of posts. These staff were subsequently successfully integrated into the Trust workforce and are providing valuable assistance.

5.3.5 Trusts need a minimum level of staffing to ensure that proper patient care can be provided safely and effectively, and, in many cases, contract staff provide the essential cover required. Nevertheless, it is imperative that contract staff are managed in an economic and effective manner.

5.3.6 A Report published by the Audit Commission[14] in 2001 examined the use of Agency nursing staff in the NHS and found that on average it costs 5 per cent more for shifts filled by agency nurses. The report also noted that Trusts in the NHS were incurring unnecessary costs, through lack of basic checks on timesheets and payments. The review of the 2003-04 and 2004-05 HPSS accounts identified instances of:

- inadequate guidance in Trust policy regarding the process of engaging agency / locum staff and the timely submission of claims;
- formal contracts not being in place;
- staff being obtained from non–contracted agencies; and
- inadequate checks of timesheets and invoices.

5.3.7 Failure to monitor hours worked might not only result in errors in payments but could also risk undermining the quality of patient care. Weaknesses were found in pre-appointment checks, which could lead to the appointment of staff who are inappropriately qualified or who have a history of unsatisfactory performance. (In England, a consultant histopathologist employed as a locum doctor by four Trusts over six years

[13] House of Commons: Written answer to PQ 1411 Mrs Iris Robinson 14 June 2005
[14] Brief Encounters: getting the best from temporary nursing staff [Audit Commission, 2001]

was found to have been responsible for the misdiagnosis of seven patients. The Commission for Health Improvement (CHI) found that none of the four Trusts involved had carried out proper background checks.)

5.3.8 The employment of contract staff may address a short term need. It does not, however, resolve the long term staffing shortages which exist in health bodies. These shortages may be due to inadequate numbers of nurses and doctors being trained; a need for better workforce planning; or simply the problem of being able to recruit properly qualified personnel in locations which might not be able to offer individuals adequate work experiences. There are also, in some places, problems of covering vacancies at short notice, which can lead to the employment of locum doctors and agency nurses at high cost. There is clearly a need to review recruitment and selection procedures for temporary staff across the health sector. This area and the effectiveness of the management of contract nursing staff and locum doctors requires further investigation and NIAO will perform a more detailed and separate review of the subject (see paragraph 8.4.3).

Charitable Trust Funds (CTF)

5.3.9 All HSS Trusts and one Special Agency, the NI Blood Transfusion Service, were required to prepare charitable trust fund accounts for each financial year to account for monies received and assets paid for through endowments and gifts. These bodies are also responsible for ensuring the regularity of transactions in respect of endowments and gifts, which requires all expenditure and income transactions to conform to the authorities which govern them. In both 2003-04 and 2004-05 the regularity opinions on the accounts relating to the charitable trust funds of the Royal Group of Hospitals and Dental Hospital Trust were qualified (see paragraphs 3.5.1 and 3.5.2).

5.3.10 The control and management of charitable trust funds could be improved generally. The review of the 2003-04 and 2004-05 accounts showed a number of instances where:

- considerable weaknesses existed in the audit trail, in terms of both donations and payments, e.g. donation receipts not issued, expenditure not supported by an invoice, approved signatories not authorising payments;
- weaknesses in documented procedures led to control weaknesses;
- terms of references for Committees required enhancement; and

- high cash balances existed**,** suggesting a need for a formal investment strategy to be developed and implemented to ensure monies are spent for the purposes intended.

5.3.11 There were also instances (e.g. Mater Trust and NI Blood Transfusion Service) where monies due to the Public Funds were wrongly recorded within the 2004-05 Charitable Trust Funds. As a result, a prior year adjustment had to be made to the 2003-04 CTF accounts and the monies were repaid to the Public Funds Account and consequently were available for expenditure on patient care.

Sickness Levels

5.3.12 Effective management of attendance in the public sector is essential, particularly in relation to service quality and efficiency. The Cabinet Office's 'Working Well Together' report, published in 1998, provides the context for much of the drive that has occurred over the past several years to reduce sickness absence throughout the public sector. It also contains a number of best practice techniques to reduce sickness levels. Within the HPSS sector, there are high levels of sickness in some bodies, for example, the NI Ambulance Service (NIAS) Trust, relative to other public sector bodies.

5.3.13 Although the percentage of contracted hours lost in the NIAS Trust fell from over 9 per cent in 2002-03 to 7 per cent in 2003-04[15]*,* this was still significantly more than the 4.4 per cent average sickness levels identified in the above Cabinet Office report for the National Health Service (as a whole) in 1996. Since then, average sickness levels have fallen. It was of some concern to note that, in 2004-05, the average sickness level at NIAS Trust was still 7 per cent. Since April 2005, figures reported to the Trust board indicate that sickness levels are increasing again with a figure of 8.2 per cent recorded for the 2005-06 year, though levels reaching well over 9 per cent in the November 2005 – January 2006 period[16]. The implications of such sickness levels include additional costs to cover absentees as well as further pressures on staff at work. With the introduction of Agenda for Change (see paragraphs 7.4.2 to 7.4.4) these costs have increased significantly. There are specific stresses affecting this particular area of the public sector. However, the Trust needs to tackle the cause of these unacceptable levels of sickness absence and if necessary revise current policy.

[15] 7% equates to approximately 16 working days based on the Cabinet Office's 225 working days per annum
[16] Northern Ireland Ambulance Service Trust Board Report – June 2006

5.4 Conclusion

5.4.1 Whilst recognising that health bodies have undergone considerable change in the past few years in terms of accounts guidance and various ongoing developments there are clearly a number of issues which need to be addressed, some in conjunction with the Department.

Section 6 Counter Fraud Measures

6.1.1 One of the basic principles of a public sector organisation is to ensure the proper stewardship of public funds. Substantial resources are spent within the HPSS sector in Northern Ireland to provide high quality treatment and care. Those involved are committed to ensuring that resources are used appropriately and efficiently to this end. Misuse of these resources creates a very real threat to the ability of DHSSPS and its associated bodies to provide front–line services.

6.1.2 All Northern Ireland Departments are required to develop anti–fraud policies, fraud policy statements and fraud response plans[17]. Within this framework, the DHSSPS Accounting Officer is responsible for establishing the internal control system designed to control the risks which the Department faces and in turn, the Accounting Officer designates the Chief Executive[18] of each HPSS body as an Accountable Officer. Responsibilities set out within the Accountable Officer Memorandum, include responsibility for safeguarding assets and for taking reasonable steps to prevent and detect fraud and other irregularities. Responsibility for countering fraud, therefore, does not rest solely with the Department.

6.1.3 This section covers the structures and measures in place across the health sector to combat fraud, and in particular, draws attention to the work of the Counter Fraud Unit within the Central Services Agency, which has key operational responsibility for tackling exemption fraud by members of the public, and fraud by primary care practitioners.

6.2 Counter fraud structures

6.2.1 The main structures in place within the health sector are:

(i) the Departmental Counter Fraud Sub–committee, which is responsible for ensuring an integrated approach is taken to all counter fraud work within the Department, its associated bodies and the wider HPSS;

(ii) the Department's Counter Fraud Policy Unit, which provides a focal point for counter fraud policy and initiatives and has been responsible for the publication of a number of key documents, including the Counter Fraud Strategy, a Fraud Policy Statement and Fraud Response Plan, and Departmental circulars advising on practical application;

[17] Government Accounting in Northern Ireland, DFP
[18] Or other designated individual with similar responsibility

(iii) the Regional Probity and Counter Fraud Steering Group, a multi–disciplinary group, including representatives from across the HPSS, which identifies regional policy issues and is supported by a number of sub-groups;

(iv) the Boards' Probity Units, which carry out checks and controls to ensure the validity of claims submitted by practitioners. This can be done in various ways, including 'checking clinics' (where independent practitioners review the quality and accuracy of the work claimed to have been carried out), visits to practices, etc. These Units are monitored by the Boards' Probity Groups and their work is directed by policies agreed by the Regional Steering Group mentioned above; and

(v) the Counter Fraud Unit (CFU), Central Services Agency, which was set up by the Department in January 2001 following an earlier NIAO report to Parliament on fraud in September 1998[19]. The Unit's role is to tackle exemption fraud by members of the public and also to investigate cases of suspected and actual fraud involving family practitioners, acting on behalf of the four Boards. The next sub–section focuses on the work of this Unit in reducing the estimated level of exemption fraud within the HPSS.

6.3 Levels of exemption and family practitioner fraud

Exemption fraud

6.3.1 A significant proportion of the population is exempt, for various reasons, from paying the statutory charge levied for prescriptions, dental treatment and ophthalmic services. Evidence collected through rigorous checking of claims by the CFU indicates that there is a considerable number of patients who are incorrectly or fraudulently claiming exemptions. As noted in sub-section 3.4, all four Boards' Accounts have been qualified for a number of years due to the level of estimated loss arising from exemption fraud and this in turn has resulted in the DHSSPS Resource Accounts for 2003-04 and 2004-05 being qualified . Figure 5 indicates the level of expenditure across the four Boards on Family Practitioner Services and the estimated levels of loss for the five years up to 2004-05:

[19] Controls to Prevent & Detect Fraud in Family Practitioner Services Payments, [HC 917], NIAO, 10 September 1998

Figure 5: Level of Board expenditure on FPS and estimated loss due to exemption fraud

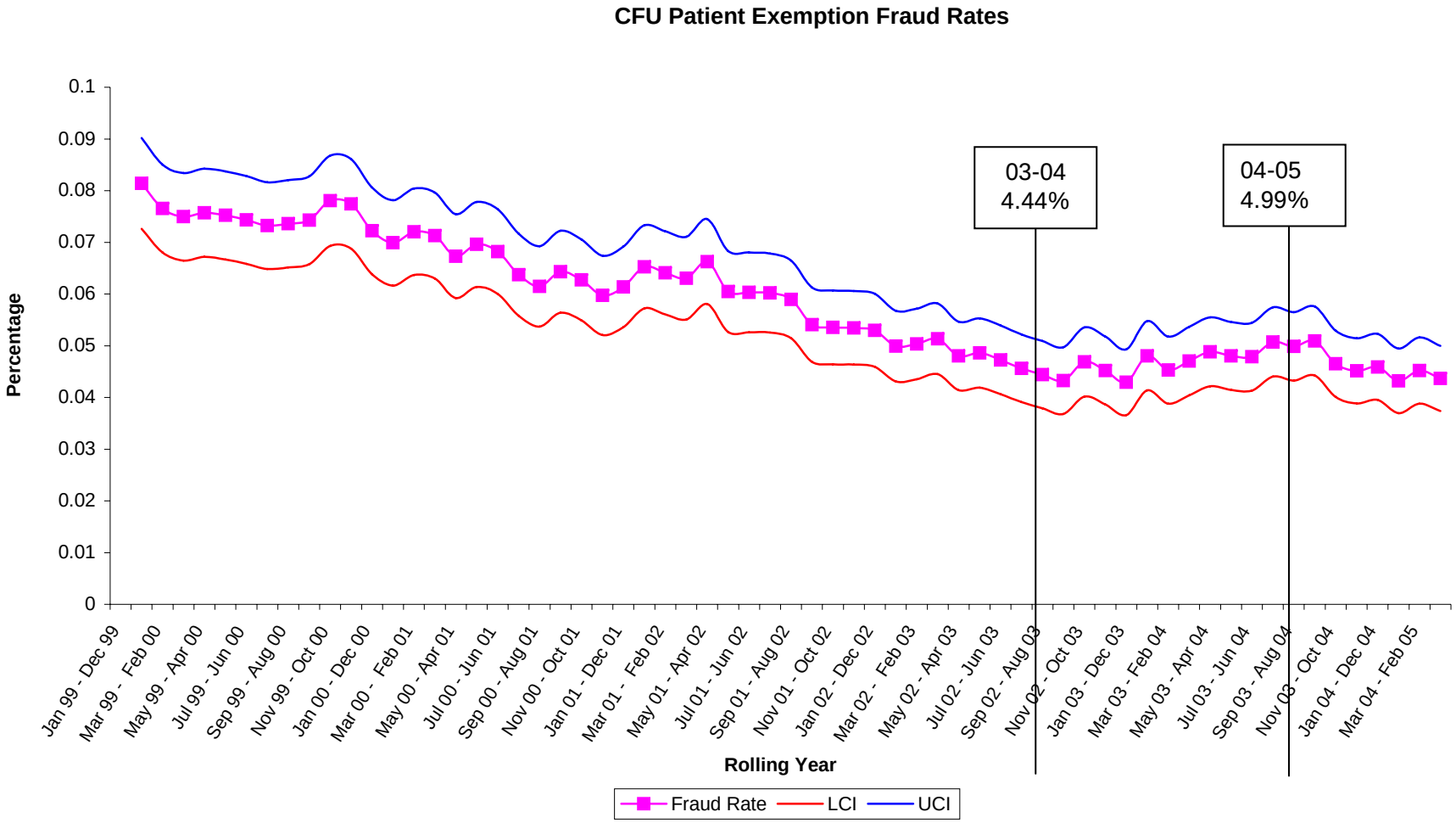
	1999-00 £m	2000-01 £m	2001-02 £m	2002-03 £m	2003-04 £m	2004-05 £m
Board expenditure	394	415	446	471	522	579
Estimated loss	Not calculated	10.2-12.4	9.0 -11.1	8.9-11.1	7.0 – 9.0	8.2 – 10.3
NI Fraud 'Best Estimate'	13.9	11.3	10.0	10.0	8.0	9.2
% Estimated financial loss[20]	3.5%	2.7%	2.2%	2.1%	1.5%	1.6%
Rebased figures[21]	17.2	12.9	11.6	11	8.5	n/a

Source: CFU, CSA Records

6.3.2 Figure 5 indicates that substantial progress has been made in reducing the level of fraud arising from incorrect exemption claims to £9.2m in 2004-05 from an estimated position of £17.2m (rebased figure) in 1999-2000. The figures for 2004-05, however, indicate that there was a slight increase in the estimated loss for the first time since 1999-2000. The CFU has advised the Department that the key trend to focus on is over a three–four year period rather than solely from one year to the next and that due to the statistically random nature of the sample selection, it would be expected that there would be variations in year-on-year results. This has been reflected in the results for 2005-06, which have continued the overall downward trend. While this news is welcomed, the Department should be careful against complacency in this area. An estimated loss of £9.2 million in 2004-05 is totally unacceptable and the Department must continue to take the necessary action to combat such fraud and promote an anti fraud culture.

[20] These figures differ from the Fraud Rate in Figure 6, as the Fraud Rate is a proportion of the claims examined.
[21] Rebased figures take into account the increase in the cost and the increase in volumes from the relevant year until 2004-05.

Figure 6:



Note: LCI = Lower Confidence Interval: UCI = Upper Confidence Interval
Source: CFU, CSA

6.3.3 Examples of other fraud detected in this area, are highlighted in the case studies below:

Case C:

An individual was required to pay over £800, including penalties and surcharges, for wrongly claiming exemptions for pharmaceutical prescriptions, dental treatment and ophthalmic services. The individual had claimed the exemptions on the grounds that he was on Income Support. This was checked with the Social Security Agency which revealed that he was not receiving any benefits. The Counter Fraud Unit's internal cross checking facility on dental and ophthalmic claims highlighted the other erroneous claims.

Case D:

Prescription forms, which had not been collected from a surgery, were passed to a Northern Ireland pharmacy by persons unknown. Subsequently, these were removed by the pharmacist and presented for payment through the pharmacist's own chemist shops in Scotland. A joint operation between CFU and CFS (Counter Fraud Services) Scotland led to the pharmacist being arrested in Scotland and charged there with various counts of theft and deception. He was also struck off from the registers of the Pharmaceutical Societies of GB and NI respectively.

Practitioner fraud

6.3.4 The majority of practitioners submit claims correctly and properly to their respective Boards for the range of services provided. There are, however, a very small minority of practitioners who fail to maintain the high level of integrity and probity necessary when dealing with public funds. Any misuse of resources must be identified and stopped, wherever possible.

6.3.5 As noted in paragraph 6.2.1 (iv), the Probity Units of the Boards perform checks on practitioner claims by a number of methods. The CSA Information Unit also provides each Board with analytical data to help them pinpoint unusual expenditure. The joined up approach being taken across the health sector in combating this area of fraud is encouraging and this should act as a deterrent. The examples below show instances where this type of fraud has arisen:

Case E:

An ophthalmic practitioner was required to repay in excess of £25,000 in relation to inappropriate claims which had been made in respect of replacement pairs of glasses. The extent of the abuse of the system was picked up through analytical work by the Counter Fraud Unit, accompanied by checking clinics held by the relevant Health Board. The optician's practice was also subject to further Board review of his prescribing practices.

Case F:

A dentist was required to repay over £50,000 in respect of erroneous claims that had been made and was reported to his professional body in relation to a wide range of clinical concerns which had arisen during the course of the investigation. An investigation had been commenced due to the high level of claims in certain areas leading to patients being recalled for examination by the DHSSPS Dental Referral Service. The Service did not find evidence to support many of the treatments for which claims had been made.

6.4 Counter fraud action being taken

6.4.1 DHSSPS has embarked upon a number of different measures to promote awareness of, and to counter, fraud across the HPSS sector. In 2004, the Department published the Counter Fraud Charter for the Family Practitioner Service in Northern Ireland[22] which sets out the aims of the ongoing counter fraud work and is a statement of commitment by the Department, professional associations, HSS Boards and CFU to work together in this area. In October 2005, it published its Counter Fraud Strategy[23] in which specific objectives are set out to work towards reducing fraud to an absolute minimum. As a result of this Strategy all Departmental staff will receive mandatory fraud awareness training and all HPSS staff have access to a dedicated fraud website via the Department's extranet site. A free phone Fraud Hotline has been set up for staff and members of the public to report any suspicions anonymously.

6.4.2 A number of measures to counter fraud have already been noted above. Other measures include:

[22] Counter Fraud Charter for the Family Practitioner Service in Northern Ireland, DHSSPS 2004
[23] Counter Fraud Strategy, DHSSPS, October 2005

- the introduction of a Fixed Penalty Charge Scheme, where those who make false claims for free prescriptions have to pay the original charge plus face a further fine of five times the original charge that should have been paid (up to a maximum of £100) which must be paid within 28 days. Furthermore, non–payment of the fixed penalty could lead to an additional surcharge of 50 per cent of the original penalty charge which must be paid within 14 days to avoid the case being taken to the Small Claims Court;
- an award-winning publicity campaign run by the Department in early 2004 aimed at deterring individuals from evading prescription, dental and ophthalmic charges. Independent research following roll-out of this initiative has concluded that public awareness of this issue was heightened by this campaign; and
- the publication of new fraud-associated guidance on overall HSS Board expenditure on General Dental Services and General Medical Services. The Department, in conjunction with the relevant professional associations, is currently working on such guidance for Pharmaceutical Services.

6.4.3 During the late Summer 2006, an investigation was launched by the Law Society (Northern Ireland), on the basis of information provided by an HSS body, into fraud alleged to have been committed in the provision of legal services to a large number of HPSS bodies. Developments on this front and in the action taken by the Department and by health bodies will be monitored and I may report on this in due course.

6.5 Way forward

6.5.1 The Department is to be commended on the wide range of initiatives being undertaken to combat fraud. It is encouraging to note that the operational role of the Counter Fraud Unit is being extended to counter all types of internal and external fraud against the HPSS.

6.5.2 All public services need to put the customer, that is the public, first when establishing policies and procedures. Consequently a number of schemes are being implemented to improve patient access and choice, for example the Minor Ailments Service, introduced late last year, which allows pharmacists to treat patients suffering from minor ailments such as colds and sore throats, and the prescription collection and delivery service offered by various pharmacies. Whilst such schemes undoubtedly improve patient choice and convenience, there is a risk that financial controls may be compromised. The Department must continuously review controls operating in these areas to ensure opportunities for fraud are limited.

6.5.3 The development of the Electronic Prescribing and Eligibility System (EPES) should have a considerable impact on reducing exemption and pharmaceutical practitioner fraud. EPES is aimed at ensuring that all claims to exemption from prescription charges are maintained on an electronic database. The contract for EPES has now been awarded and the system is scheduled to go live in September 2007. This will initially be in 10 per cent of pharmacies, and it is likely to take another 12 months before the system is rolled out to all pharmacies.

Section 7 Current and Future Developments

7.1.1 This section of the report sets out the various initiatives that are being implemented within the HPSS sector and their potential impact. A brief summary of the Review of Public Administration proposals which will result in the most significant reform in this sector in the last 30 years is also provided.

7.2 Review of Public Administration

7.2.1 The Review of Public Administration (RPA), set up by the Government to undertake a radical overhaul of the public sector in Northern Ireland, reported in November 2005, and again in March 2006. All areas of the public sector were covered by the Review and, following an extensive consultation exercise, major structural changes were announced in the health sector and elsewhere.

7.2.2 In November 2005, the Secretary of State for Northern Ireland announced that:

- 18 of the 19 Health Trusts would be wound up and replaced by 5 new Trusts from 1 April 2007;
- 4 Health Boards would be wound up and replaced by a new strategic Health and Social Services Authority from 1 April 2008;
- 7 new Local Commissioning Groups would be created, co-terminous with the proposed 7 new Local Government Councils, but administratively part of the new Authority and commencing operations from 1 April 2008;
- The 19th Trust, the regional NI Ambulance Service Trust, and several smaller Agencies, would continue to operate independently, whereas other Agencies would merge with the new Trusts or the new Authority.

7.2.3 The proposed RPA changes have not had any impact on the two years' accounts covered by this report. However, developments are being monitored. Of particular interest is how health bodies have prepared or are preparing for the changes, and how they cope with, not only the technical and procedural aspects of major change, but also how they ensure that functions and resources are maintained at a sufficiently high level right up to the time when those bodies are dissolved and functions

are transferred to the new bodies. These issues will be discussed further in the report on the 2005-06 accounts.

7.3 Faster Closure / Whole of Government Accounts

7.3.1 HM Treasury has launched an initiative aimed at ensuring that, by 2006, resource accounts of all Departments in Great Britain were laid before Parliament before the Summer Recess. The NI Departments are required to meet the Treasury deadline by July 2008 using a rolling programme of bringing the deadline forward each year until then. The production and clearance of HSS Boards' accounts has been brought forward as they are within the departmental resource account boundary. This also impacts on the Central Services Agency which provides key information to the Boards.

7.3.2 While the other HPSS bodies do not fall within the departmental resource account boundary, they will be part of Whole of Government Accounts (WGA), which are intended to be commercial-style accounts covering the whole of the public sector. Like departmental resource accounts, WGA will be produced on an accruals basis and will use generally accepted accounting principles, adapted where necessary for government. The overview of the public sector finances provided by WGA will improve government's accountability to Parliament and taxpayers, and form an important element in the Modernising Government agenda.

7.3.3 The requirement to prepare these accounts is legislative[24] and whilst no date has been prescribed for their publication, Treasury have planned for the first published WGA to cover 2006-07. Both 2004-05 and 2005-06 were dry run years. This process is dependent on Departments being able to submit prompt and accurate returns to Treasury. This timetable will undoubtedly present a considerable challenge to the public sector, and particularly to the health sector, as it will not be part of the Accounting Services Programme which will modernise accounting structures.

7.3.4 In Autumn 2000, the Strategic Finance Forum of Health Service finance directors agreed that it was necessary for the system needs of finance and related functions of the HPSS to be re-examined, with the aim of producing a strategic context statement and outline business case for replacing current financial systems for the whole of the sector. The HPSS Information and Communications Technology (ICT) Strategy – Vision Statement was issued for consultation in June 2001 and the HPSS ICT Strategy was published in March 2005, when the ICT Programme was launched. A feasibility study has been completed into the potential for

[24] Articles 14 -16 of the Government Resources and Accounts Act (NI) 2001

shared services and work is ongoing to update the finance system outline business case in this context. The Department is to be commended for developing this Strategy. However, there must be some concern that its implementation, particularly in respect of business systems, is not progressing in tandem with faster closure expectations. The Department told us that, as a consequence of financial resource constraints within the ICT programme, difficulties in finalising the business cases, and the need to re-examine the case for shared services, procurements for replacement systems have not yet begun.

7.3.5 As the existing IT systems within the health sector already require a lot of manual input to produce the accounts, it is recognised that it is particularly onerous for these bodies to prepare their accounts faster. Coupled with this, the implementation of the RPA proposals will also provide a further challenge. It is imperative therefore that health bodies continue to implement and update action plans identifying key processes and procedures which need to be completed to enable faster closing, coupled with clear internal target dates and designated responsibilities. Furthermore, health bodies should already be:

- producing regular accounts prepared on a full accruals basis;
- using, where necessary, appropriate methods for the determination of estimates, for example, for prepayments and accruals;
- ensuring that there is earlier agreement between HPSS bodies on intra-group transaction streams and balances; and
- ensuring that they have sufficient staff with the appropriate experience and qualifications to meet their needs.

7.3.6 Although the implications of the changes brought about by the Review of Public Administration may be further up their list of priorities, the support of senior management and the board is vital in driving forward faster closure by ensuring that it is seen as an integral part of the accounting and business processes. The Audit Committee can also support the board in driving through the change and improvements needed.

7.3.7 Another key resource that can be utilised to facilitate faster closure is Internal Audit. Internal Audit can assist in areas such as the verification of estimation techniques, in–year management accounts information, validation of returns and completion tests for year end balances.

7.3.8 All Health bodies are encouraged to work closely with their Internal Auditors, the contracted external audit firms and NIAO to achieve these challenging deadlines.

7.4 Funding Issues

7.4.1 This part of the report highlights a number of financial pressures currently affecting the HPSS sector, the most significant of which are Agenda for Change and the new Consultants' Contract.

Agenda for Change

7.4.2 Agenda for Change encompasses a new pay system for all staff excluding doctors and senior executives. It is anticipated that the new system will offer greater scope to create new kinds of jobs, bring more patient-centred care, more varied and stimulated roles for HPSS staff, fairer pay, harmonised conditions of service, a more transparent system of rewards for staff who work flexibly outside normal working hours and better links between career and pay progression.

7.4.3 Implementation of the new pay structure, following consultation and agreement, was introduced in some pilot sites in England during 2003 to ensure that the systems were robust and adequately tested for national roll-out. Following successful piloting and since October 2004, the new pay structure has been implemented across the NHS / HPSS.

7.4.4 In May 2005 the Department advised the various HPSS bodies what the basis and breakdown of their individual allocations would be. Consequently, an accrual for Agenda for Change was recognised in the 2004-05 accounts of all HPSS bodies. The review of the 2004-05 accounts indicates that there was still uncertainty surrounding the exact financial impact of Agenda for Change as re-basing exercises had not then been completed for the HPSS bodies. A number of bodies were proactive in assessing the reasonability of the accrual allocated by the Department, based on matching and assimilations performed at the date of the production of the accounts. However, there was some concern that these calculations did not always match the Department's figures, for example, one Trust estimated the additional costs of Agenda for Change to be £2,475,000 against a DHSSPS indicative allocation of £1,500,000 (Newry & Mourne). Funding was subsequently provided by the Department to meet the shortfall.

Consultants' Contract

7.4.5 The new Consultants' Contract is designed to provide a much more effective system of planning and timetabling consultants' duties and activities. For employers, this will mean the ability to manage consultants' time in ways that best meet local service needs and priorities. For consultants, it will mean greater transparency about the commitments expected of them by the HPSS and greater clarity over the support that they need from employers to make maximum effective contribution to improving patient services. There have been varying degrees of progress across the Trusts in terms of assessing the impact of this initiative and the signing of new contracts. Where contracts had not been signed by the end of the period under review, Trusts appear to have adopted a reasonable basis of estimation for their accrual either in line with the Department's guidance or based on their own estimation, although the accrual by one of the Trusts was £2.3m in excess of the funding made available (Royal Group of Hospitals Trust).

New Deal for Junior Doctors

7.4.6 The New Deal, agreed in 1991 by representatives of the profession, NHS Management and the government, is a package of measures designed to improve the conditions under which Junior Doctors work. One of the key features is to place limits on the number of hours of work. The New Deal was refined in 1999 in terms of shift patterns and rest requirements along with a new pay structure for doctors. From August 2003, it has been a contractual obligation for Trusts to ensure all junior doctors in training comply with the New Deal and that they do not work in excess of 56 hours a week.

European Working Time Directive (EWTD)

7.4.7 The European Working Time Regulations were introduced into Northern Ireland in 1998. These Regulations created measures designed to protect the health and safety of workers and aim to 'improve health and safety at work by introducing minimum rules for employees relating to daily and weekly rest periods, rest breaks, annual leave entitlements, length of working week, and on night work.' Some groups of workers were initially excluded from these regulations, including doctors in training. However, from August 2004, the provisions of the EWTD apply to doctors in training in the UK. These provisions mean that the Department must ensure doctors in training can work safely and effectively without excessive workloads that might compromise patient care.

7.4.8 Some HPSS bodies are experiencing difficulties in terms of reduced working hours for doctors. As this has a direct impact on the number of doctors required, the problem of attracting professionals is increased and ultimately is a contributing factor towards the high increase in locum costs (see paragraph 5.3.8).

General Medical Services (GMS) Contract

7.4.9 In June 2003, GPs voted throughout the United Kingdom to accept a new contract for the delivery of general medical services. The new contract which came into effect on 1 April 2004 was accompanied by substantial uplift in investment of 33 per cent a year over the following three years. The new contract was designed to bring about a range of improvements in primary care in providing demonstrable benefits to general practitioners, to other healthcare professionals, to the Health Service in general and most importantly to patients. The major changes introduced by the contract have been in terms of out–of–hours service, information and management technology, premises, focus on quality, patient experience and range of services provided.

7.4.10 2004-05 was the first year of the new GMS contract. Budgets for 2005-06 were set assuming that practices would meet their performance targets, and HPSS Boards have continued to be under pressure to ensure variances are kept to a minimum. Significant departures from target may have a considerable impact on a Board's financial position. The Boards must also ensure that systems in place for monitoring performance are robust. The new programme of detailed probity checking that has been initiated for expenditure incurred under the dental and medical contracts, as noted in Section 6, is welcomed.

7.5 Private Finance Initiative

7.5.1 The Private Finance Initiative (PFI) is a key part of the Government's strategy for delivering high quality and cost effective public services. In the health sector the HPSS will continue to be responsible for providing clinical care to patients but, where capital investment is required, and where it can be demonstrated that a project will bring about value for money, consideration may be given to an increased role for a private sector partner in the provision of facilities. PFI is about building long term and mutually beneficial partnerships between the public and private sectors. Since its introduction in 1998, where public funds have not been available, a number of schemes have been initiated using the PFI approach for funding. These include a wide range of projects, from the

management and disposal of clinical waste, equipment leasing and the provision of new renal units to major hospital construction.

7.5.2 Fundamental to any major capital investment project is this issue of value for money. For large scale capital projects, the best choice of procurement and the appropriateness of PFI must be assessed. Where PFI is considered to be the most economically advantageous, the balance sheet treatment of assets emerging from the PFI project should not generally be relevant to the decision to proceed. The decision to use PFI should be based on value for money considerations alone. Despite this clear message from HM Treasury, some public bodies (including health bodies) continue to be disinclined to accept audit judgements, following review and discussion that, in certain circumstances, an asset created under PFI should be accounted for on the body's balance sheet. It is important that such reluctance should not distort the choice of procurement method and ultimately the achievement of value for money. The pervading view seems to be that securing off balance sheet treatment goes hand in hand with securing value for money. This is not necessarily the case.

7.5.3 In terms of the accounting treatment, the Treasury directives[25] set out clearly the progressive stages at which a public body contemplating the PFI route to procurement should obtain the views of the auditor and indeed, what the responsibilities of the auditor are at these stages. Where the initial external audit view is given by a private sector firm to which the audit has been contracted, NIAO also expects to be consulted. In each case, auditors should be consulted at an early stage.

7.5.4 The auditor's responsibility is to provide a view on the reasonableness of the purchaser's view of the accounting treatment. It is not his role to act as an accounting adviser. The audited body, using whatever professional advice it deems necessary, must reach its own accounting opinion. NIAO will then consider the accepted opinion.

7.5.5 NIAO has been consulted on only three PFI projects; namely the Altnagelvin Hospital Trust's Laboratory and Pharmacy Service Centre, the Royal Group of Hospitals and Dental Hospital Trust's Medical Equipment and Clinical Information Systems Project and the Belfast City Hospital Trust's Cancer Centre Equipment Project. All of these consultations were received late in the PFI procurement process, at the Full Business Case stage.

7.5.6 In addition to the Treasury requirements, the Accounting Standards Board has set out how the principles and requirements of its standards are

[25] HM Treasury Taskforce Technical Note 1 (Revised): How to Account for PFI Transactions, 1999.

applied to PFI transactions[26]. These cases can lead to difficult issues of accounting judgement and, where possible, an agreed accounting treatment should be reached through discussion with the audited body. When this is not possible, in order to maintain the credibility of the financial statements across the sector and the eventual Whole of Government Accounts, NIAO will follow the accounting guidance as it deems appropriate. In the main, when the public sector has retained significant demand risk and residual value risk, the asset and associated liability is likely to be assessed as requiring to be on the balance sheet of the body. Whilst the guidance is currently under review, all HPSS bodies need to continue to follow incumbent guidance and to seek the opinion of NIAO at an early stage of such a procurement route.

7.5.7 As part of the Government's Reinvestment and Reform Initiative, the Strategic Investment Board (SIB) was established in April 2003 to bring new expertise and speedier delivery to public sector infrastructural developments. The SIB is now engaged in a wide range of major health sector projects.

7.6 Way forward

7.6.1 The next few years are undoubtedly going to present a considerable challenge to the HPSS sector especially with respect to the Review of Public Administration. During this period of transition it is imperative that HPSS bodies do not lose sight of the fact that additional risks arising will need to be adequately managed and fully incorporated into the planning and decision making processes of the organisation. Accountable Officers will still be responsible for meeting their obligations, as set out in the Accountable Officer Memorandum issued by the Department, until their current organisation ceases to exist or is restructured.

[26] Application Note to FRS 5

Section 8 Value for Money Update

8.1.1 In addition to undertaking the financial audits of the accounts of public sector bodies, NIAO carries out value for money reviews:

- to provide the Assembly / Parliament with independent information and advice about how economically, efficiently and effectively departments, agencies and other central government public bodies have used their resources;
- to encourage audited bodies to improve their performance in achieving value for money and implementing policy; and
- to identify good practice and suggest ways in which public services could be improved.

8.1.2 The results of this value for money work are normally reported to the Northern Ireland Assembly, although during periods of suspension, results have been reported directly to Parliament. The Assembly's Public Accounts Committee or Westminster's Committee of Public Accounts take evidence from senior officials on all reports and, following consideration of the evidence provided, report their findings and recommendations to the Assembly or to Parliament. The Northern Ireland Executive is required to respond to the recommendations of either Committee, specifying the action the audited body intends to take. At a later stage NIAO and the Department of Finance and Personnel monitor the action taken.

8.2 Published Reports

8.2.1 In recent years, NIAO has published the following reports[27] regarding health issues:

- The Use of Operating Theatres in the HPSS (April 2003);
- The Private Finance Initiative: A Review of the Funding and Management of Three Projects in the Health Sector (February 2004);
- The Management of Surplus Land and Property in the Health Estate (February 2004);
- Waiting for Treatment in Hospitals (November 2004);
- Education and Health and Social Services Transport (June 2005); and
- Private Practice in the Health Service (May 2006); and
- Outpatients: Missed Appointments and Cancelled Clinics (April 2007).

[27] Copies of all published reports can be obtained via the NIAO website at www.niauditoffice.gov.uk.

8.3 Latest Report – Outpatients: Missed Appointments and Cancelled Clinics

8.3.1 This report examined missed outpatient appointments and cancelled clinics in the health service, against a background of efforts to reduce outpatient waiting times.

8.3.2 In June 2006, the Department of Health, Social Services and Public Safety (the Department) announced a target that, by March 2007, no patient would be waiting longer than 26 weeks for a first outpatient appointment. On the basis of the information available to the Department at the beginning of April, the outpatient target was achieved and the report welcomed the fact that all patients were being seen within 26 weeks of GP referral.

8.3.3 However, the Report also shows that in line with the rest of the UK, at present, the only detailed information being collected is on attendances at clinics led by consultants. Systems currently do not identify information on the trend for other outpatient clinics to be led by other health care professionals such as nurses and physiotherapists.

8.3.4 The majority of people show a responsible attitude to attendance at outpatient appointments or notify the clinic if they are unable to do so. However, a Departmental census showed that one in ten outpatients is "not seen". These individuals are a combination of those who will either have had their appointments cancelled by Trusts, cancelled their own appointments and those who simply did not attend. The potential cost to taxpayers of outpatients who are not seen at clinics is estimated at around £11.6 million annually. On this basis, each one per cent reduction in outpatients not seen might generate an annual efficiency gain of £1 million. In addition to the substantial financial costs for the health service, there may also be clinical implications for those not seen and other patients on the waiting list.

8.3.5 Failure to attend outpatient appointments can waste valuable time and resources. A comparison with Great Britain shows that Northern Ireland has consistently had the highest overall rate of non-attendance. The Report called on Trust managers and clinicians to investigate further the factors influencing non-attendance at clinics to allow the planning of effective strategies to counteract these. The Department is tackling outpatient waiting times through a major programme of service reform.

Work-in-progress

8.4.1 The following areas are being reviewed, with the intention of publishing reports in 2007:

Older People and Domiciliary Care

8.4.2 In 1990, the Department published *People First* which noted the following as one of its key objectives:

> '*To promote the development of domiciliary, day and respite services to enable people to live in their own homes wherever feasible and sensible.'*
>
> The desired outcome was that commissioning of care services for older people would transform a care system which, at that time, was dominated by residential care. The Department published a *Review of Community Care* in 2002 which identified a number of barriers to progress in meeting the policy objectives of *People First* and thereby ensuring that older people received high quality care services which enable them to live at home.
>
> The NIAO review has investigated, through financial and activity analysis and performance review, whether the policy objective~~s~~ of shifting the balance of community care provision for older people towards care in their own home, is being achieved.

Locum Doctors

8.4.3 As noted in paragraph 5.3.8, a review will be undertaken into the use of locum doctors, with particular focus on the effectiveness of management arrangements in this area.

Overview of the Performance of the Health Service

8.4.4 This review is focussed on the Department's progress against Public Service Agreement targets. It is planned to cover major dimensions of health status such as reductions in the levels of cigarette smoking, drug taking, obesity, suicide and teenage pregnancies as well as outcomes for clinical treatments such as cancer, heart disease and diabetes.

8.4.5 This report will also update the position on overall hospital waiting times performance and assess the rate of progress against recommendations made in our report on inpatient and outpatient hospital waiting lists.

Accident and Emergency (A& E) Services

8.4.6 This review will examine the progress that has been made in reducing long waiting times in accident and emergency departments, through the more effective management of patient flows within those departments.

8.4.7 Updates on work in progress can also be obtained from NIAO's website (http:www.niauditoffice.gov.uk).

	HPSS Body	Financial Management	Governance	Risk Management	Human Resources	Medical Devices	Medicines Management
	Expected levels of compliance	**Substantive**	**Substantive**	**Substantive**	**Moderate**	**Moderate**	**Moderate**
Boards	Eastern Health & Social Services Board						
	Northern Health & Social Services Board						
	Southern Health & Social Services Board						
	Western Health & Social Services Board						
HPSS Agencies	Central Services Agency*	**Unavailable**	**Unavailable**	**Unavailable**	**Unavailable**	**Unavailable**	**Unavailable**
	NI Health Promotion Agency						
	NI Blood Transfusion Service						
	NI Guardian Ad Litem Agency						
	NI Regional Medical Physics Agency						
HSS Trusts	Armagh & Dungannon						
	Altnagelvin Hospital						
	Belfast City Hospital						
	Causeway						
	Craigavon Area Hospital Group						
	Craigavon & Banbridge Community						
	Down Lisburn						
	Foyle						
	Greenpark Healthcare						
	Homefirst Community						
	Mater Infirmorium						
	Newry & Mourne						
	North & West Belfast Community						
	NI Ambulance Service						
	Royal Group of Hospitals & Dental Hospital						
	South & East Belfast Community						
	Sperrin Lakeland						
	Ulster Community & Hospitals Trust						
	United Hospitals						

*** CSA self assessment results contradicted internal and external audit assessment and were therefore withdrawn.**

Key — Substantive; Minimal; Moderate; Not Applicable

Compliance with Controls Assurance Standards for 2004-05

APPENDIX 1b

	HPSS Body	Financial Management	Governance	Risk Management	Fire Safety	Infection Control	Decon'nation of medical devices	Human Resources	Medical Devices and Equipment Management	Medicines Management	Buildings, land, plant and non-medical	Environment Management	Health and Safety	ICT	Waste Management
	Expected levels of compliance	**Substantive**	**Substantive**	**Substantive**	**Substantive**	**Substantive**	**Substantive**	**Moderate**	**Moderate**	**Moderate**	**Moderate**	**Moderate**	**Moderate**	**Moderate**	**Moderate**
Boards	Eastern Health & Social Services Board														
	Northern Health & Social Services Board														
	Southern Health & Social Services Board														
	Western Health & Social Services Board														
HPSS Agencies	Central Services Agency*														
	NI Health Promotion Agency														
	NI Blood Transfusion Service														
	NI Guardian Ad Litem Agency														
	NI Medical & Dental Training Agency														
	NI Regional Medical Physics Agency														
HSS Trusts	Armagh & Dungannon														
	Altnagelvin Hospital														
	Belfast City Hospital														
	Causeway														
	Craigavon Area Hospital Group														
	Craigavon & Banbridge Community														
	Down Lisburn														
	Foyle														
	Greenpark Healthcare														
	Homefirst Community														
	Mater Infirmorium														
	Newry & Mourne														
	North & West Belfast Community														
	NI Ambulance Service														
	Royal Group of Hospitals & Dental Hospital														
	South & East Belfast Community														
	Sperrin Lakeland**		Undetermined	Undetermined											
	Ulster Community & Hospitals Trust														
	United Hospitals														

*** The 2004-05 CSA Accounts have not yet been certified. These scores are based on CSA self assessments.**

**** Scores withdrawn as a result of findings emerging from the NHS Clinical Governance Support Team's review**

Key: Substantive; Moderate; Minimal; Not Applicable

Performance against targets disclosed in the 2003-04 Accounts **APPENDIX 2a**

(See Section 2)

	HPSS Body	* Results Before Provision £	Results After Provision £	Trust Management Costs %	Capital Cost Absorption %	EFL		
						Limit £	Actual £	Difference £
Boards	Eastern Health & Social Services Board	-101,000	-73,000	n/a	n/a	n/a	n/a	n/a
	Northern Health & Social Services Board	-544,000	59,000	n/a	n/a	n/a	n/a	n/a
	Southern Health & Social Services Board	199,000	435,000	n/a	n/a	n/a	n/a	n/a
	Western Health & Social Services Board	35,000	46,000	n/a	n/a	n/a	n/a	n/a
HPSS Agencies	Central Services Agency*	279,000	14,237,000	n/a	n/a	n/a	n/a	n/a
	NI Health Promotion Agency	716	716	n/a	n/a	n/a	n/a	n/a
	NI Blood Transfusion Service	127,000	90,000	n/a	n/a	n/a	n/a	n/a
	NI Guardian Ad Litem Agency	-21,000	-21,000	n/a	n/a	n/a	n/a	n/a
	NI Regional Medical Physics Agency	162,000	171,000	n/a	n/a	n/a	n/a	n/a
HSS Trusts	Armagh & Dungannon	16,000	22,000	4.70	3.68	1,582,000	1,563,000	19,000
	Altnagelvin Hospital	9,000	214,000	3.80	4.40	7,244,000	7,244,000	0
	Belfast City Hospital	39,000	116,000	3.10	4.02	23,949,000	23,934,000	15,000
	Causeway	27,000	36,000	5.10	4.00	694,000	-3,302,000	3,996,000
	Craigavon Area Hospital Group	3,000	141,000	3.70	1.80	-866,000	-2,040,000	1,174,000
	Craigavon & Banbridge Community	20,000	-120,000	5.10	2.70	3,720,000	969,000	2,751,000
	Down Lisburn	45,000	106,000	4.40	3.70	3,072,000	974,000	2,098,000
	Foyle	21,000	-83,000	4.43	3.95	996,000	992,000	4,000
	Greenpark Healthcare	45,000	164,000	5.10	3.92	6,631,000	3,224,000	3,407,000
	Homefirst Community	8,000	-39,000	3.80	4.00	5,350,000	3,371,000	1,979,000
	Mater Infirmorium	71,700	-6,500	4.30	4.90	3,833,000	2,213,023	1,619,977
	Newry & Mourne	5,000	27,000	3.80	4.20	1,149,000	949,000	200,000
	North & West Belfast Community	7,000	148,000	4.40	5.00	-2,424,000	-2,663,000	239,000
	NI Ambulance Service	7,000	97,000	6.40	5.60	2,568,000	2,565,000	3,000
	Royal Group of Hospitals & Dental Hospital	30,000	616,000	3.69	2.90	7,072,000	6,228,000	844,000
	South & East Belfast Community	48,000	142,000	4.10	3.60	4,671,000	4,350,000	321,000
	Sperrin Lakeland	-135,000	-180,000	4.12	3.20	7,526,000	4,280,000	3,246,000
	Ulster Community & Hospitals Trust	39,000	-60,000	3.40	4.40	6,496,000	-7,029,000	13,525,000
	United Hospitals	95,000	86,000	4.20	3.88	8,064,000	6,788,000	1,276,000

* Breakeven measured before provision taken into account

Note: Where financial performance targets are not met, entries are shown in red.

Performance against targets disclosed in the 2003-04 Accounts

APPENDIX 2a (continued)

(See Section 2)

	HPSS Body	CRL			Prompt Payments	
					Value	Volume
		Limit £	Actual £	Difference £	< 30 Days %	< 30 Days %
Boards	Eastern Health & Social Services Board	n/a	n/a	n/a	97.88	95.19
	Northern Health & Social Services Board	n/a	n/a	n/a	95.44	90.89
	Southern Health & Social Services Board	n/a	n/a	n/a	89.69	89.77
	Western Health & Social Services Board	n/a	n/a	n/a	99.60	98.79
HPSS Agencies	Central Services Agency*	n/a	n/a	n/a	86.40	76.50
	NI Health Promotion Agency	n/a	n/a	n/a	99.50	95.70
	NI Blood Transfusion Service	n/a	n/a	n/a	94.90	92.20
	NI Guardian Ad Litem Agency	n/a	n/a	n/a	91.40	93.50
	NI Regional Medical Physics Agency	n/a	n/a	n/a	89.53	87.87
HSS Trusts	Armagh & Dungannon	2,287,000	2,287,000	0	92.70	86.40
	Altnagelvin Hospital	9,581,000	9,572,000	9,000	92.80	91.50
	Belfast City Hospital	27,259,000	25,105,000	2,154,000	81.90	73.00
	Causeway	3,641,000	2,994,000	647,000	92.20	85.40
	Craigavon Area Hospital Group	4,117,000	2,944,000	1,173,000	90.80	85.30
	Craigavon & Banbridge Community	1,219,000	1,237,000	**-18,000**	96.70	95.10
	Down Lisburn	4,754,000	4,741,000	13,000	**78.60**	86.00
	Foyle	4,537,000	3,890,000	647,000	96.00	68.00
	Greenpark Healthcare	6,321,000	5,215,000	1,106,000	96.40	96.40
	Homefirst Community	6,636,000	4,109,000	2,527,000	94.60	82.60
	Mater Infirmorium	4,477,000	2,496,415	1,980,585	95.30	94.90
	Newry & Mourne	2,283,000	1,491,000	792,000	96.30	95.30
	North & West Belfast Community	3,796,000	3,255,000	541,000	88.70	84.70
	NI Ambulance Service	4,804,000	4,797,000	7,000	95.90	88.90
	Royal Group of Hospitals & Dental Hospital	16,266,000	16,266,000	0	**78.00**	75.60
	South & East Belfast Community	10,756,000	9,103,000	1,653,000	91.50	78.80
	Sperrin Lakeland	4,928,000	4,532,000	396,000	98.20	96.50
	Ulster Community & Hospitals Trust	10,118,000	6,548,000	3,570,000	86.40	77.50
	United Hospitals	10,294,000	8,835,000	1,459,000	86.90	88.00

Performance against targets disclosed in the 2004-05 Accounts **APPENDIX 2b**

(See Section 2)

	HPSS Body	* Results Before Provision £	Results After Provision £	Trust Management Costs %	Capital Cost Absorption %	EFL		
						Limit £	Actual £	Difference £
Boards	Eastern Health & Social Services Board	-80,000	22,000	n/a	n/a	n/a	n/a	n/a
	Northern Health & Social Services Board	302,000	791,000	n/a	n/a	n/a	n/a	n/a
	Southern Health & Social Services Board	208,000	206,000	n/a	n/a	n/a	n/a	n/a
	Western Health & Social Services Board	38,000	49,000	n/a	n/a	n/a	n/a	n/a
HPSS Agencies	Central Services Agency	24,863~	12,354,804~	n/a	n/a	n/a	n/a	n/a
	NI Health Promotion Agency	895	895	n/a	n/a	n/a	n/a	n/a
	NI Blood Transfusion Service	-33,069	-14,070	n/a	n/a	n/a	n/a	n/a
	NI Guardian Ad Litem Agency	2,000	2,000	n/a	n/a	n/a	n/a	n/a
	NI Medical & Dental Training Agency	106,643	104,562	n/a	n/a	n/a	n/a	n/a
	NI Regional Medical Physics Agency	12,859	10,765	n/a	n/a	n/a	n/a	n/a
HSS Trusts	Armagh & Dungannon	1,000	-14,000	4.70	4.10	-344,000	-582,000	238,000
	Altnagelvin Hospital	29,000	73,000	3.70	3.30	2,872,000	2,872,000	0
	Belfast City Hospital	41,000	-38,000	3.00	4.47	6,278,000	6,267,000	11,000
	Causeway	20,000	-89,000	4.90	3.60	-1,603,000	-2,004,000	401,000
	Craigavon Area Hospital Group	3,000	31,000	3.80	2.60	3,816,000	3,343,000	473,000
	Craigavon & Banbridge Community	15,000	58,000	5.30	2.80	4,520,000	1,561,000	2,959,000
	Down Lisburn	67,000	-328,000	4.20	3.80	1,431,000	-1,538,000	2,969,000
	Foyle	3,000	-17,000	4.46	4.17	3,884,000	3,859,000	25,000
	Greenpark Healthcare	29,000	-202,000	4.90	4.00	4,930,000	-208,000	5,138,000
	Homefirst Community	14,000	123,000	3.80	3.70	1,848,000	-3,243,000	5,091,000
	Mater Infirmorum	-44,262	49	4.60	4.00	3,944,000	754,900	3,189,100
	Newry & Mourne	41,000	205,000	3.80	5.90	1,174,000	297,000	877,000
	North & West Belfast Community	45,000	-92,000	4.40	4.70	-330,000	-610,000	280,000
	NI Ambulance Service	10,000	137,000	6.30	8.30	-113,000	-168,000	55,000
	Royal Group of Hospitals & Dental Hospital	117,000	394,000	3.64	4.20	2,957,000	175,000	2,782,000
	South & East Belfast Community	22,000	77,000	3.80	4.40	21,715,000	9,726,000	11,989,000
	Sperrin Lakeland	-92,000	14,000	4.07	4.00	2,820,000	-360,000	3,180,000
	Ulster Community & Hospitals Trust	25,000	140,000	3.30	4.55	13,816,000	12,601,000	1,215,000
	United Hospitals	14,000	110,000	4.20	3.80	2,911,000	608,000	2,303,000

* Breakeven measured before provision taken into account

~ per final Agency approved accounts

Note: Where financial performance targets are not met, entries are shown in red.

Performance against targets disclosed in the 2004-05 Accounts

APPENDIX 2b (continued)

(See Section 2)

HPSS Body		CRL			Prompt Payments	
					Value	Volume
		Limit £	Actual £	Difference £	< 30 Days %	< 30 Days %
Boards	Eastern Health & Social Services Board	n/a	n/a	n/a	97.48	94.68
	Northern Health & Social Services Board	n/a	n/a	n/a	95.03	89.66
	Southern Health & Social Services Board	n/a	n/a	n/a	91.74	89.48
	Western Health & Social Services Board	n/a	n/a	n/a	98.00	95.37
HPSS Agencies	Central Services Agency	n/a	n/a	n/a	97.40	89.70
	NI Health Promotion Agency	n/a	n/a	n/a	98.11	94.10
	NI Blood Transfusion Service	n/a	n/a	n/a	93.10	95.64
	NI Guardian Ad Litem Agency	n/a	n/a	n/a	95.69	94.73
	NI Medical & Dental Training Agency	n/a	n/a	n/a	81.68	89.33
	NI Regional Medical Physics Agency	n/a	n/a	n/a	97.24	92.53
HSS Trusts	Armagh & Dungannon	1,975,000	1,993,000	-18,000	92.82	82.19
	Altnagelvin Hospital	10,581,000	10,496,000	85,000	94.60	93.10
	Belfast City Hospital	21,630,000	20,172,000	1,458,000	80.40	74.60
	Causeway	2,590,000	1,601,000	989,000	93.00	87.40
	Craigavon Area Hospital Group	4,852,000	4,367,000	485,000	89.86	83.74
	Craigavon & Banbridge Community	2,903,000	2,791,000	112,000	96.70	94.10
	Down Lisburn	7,183,000	7,178,000	5,000	82.60	83.70
	Foyle	5,829,000	5,246,000	583,000	96.00	82.00
	Greenpark Healthcare	6,450,000	6,073,000	377,000	98.10	97.70
	Homefirst Community	5,008,000	2,431,000	2,577,000	95.00	83.30
	Mater Infirmorum	5,240,000	2,951,800	2,288,200	91.60	93.40
	Newry & Mourne	3,414,000	2,905,000	509,000	93.30	91.70
	North & West Belfast Community	10,672,000	5,732,000	4,940,000	88.70	83.40
	NI Ambulance Service	2,936,000	2,934,000	2,000	94.60	90.50
	Royal Group of Hospitals & Dental Hospital	23,591,000	23,579,000	12,000	86.60	87.20
	South & East Belfast Community	16,235,000	16,061,000	174,000	93.80	84.40
	Sperrin Lakeland**	4,637,000	4,624,000	13,000	98.50	97.00
	Ulster Community & Hospitals Trust	19,575,000	18,549,000	1,026,000	85.90	78.10
	United Hospitals	8,163,000	6,900,000	1,263,000	89.00	88.40

Disclosure of salary details within the 2003-04 Accounts **APPENDIX 3a**

(See Section 4)

	HPSS Body	Extract of Disclosure In Accounts *
Boards	Eastern Health & Social Services Board	Full disclosure by all senior executives.
	Northern Health & Social Services Board	Full disclosure by three senior executives. Consent to disclosure withheld by eleven senior executives.
	Southern Health & Social Services Board	Full disclosure by all senior executives.
	Western Health & Social Services Board	Full disclosure by all senior executives.
HPSS Agencies	Central Services Agency	Full disclosure by all senior executives.
	NI Health Promotion Agency	Partial disclosure by the senior executive.
	NI Blood Transfusion Service	Consent to disclosure withheld by the senior executive.
	NI Guardian Ad Litem Agency	Full disclosure by the senior executive.
	NI Regional Medical Physics Agency	Consent to disclosure withheld by all senior executives.
HSS Trusts	Armagh & Dungannon	Full disclosure by two senior executives. Consent to disclosure withheld by nine senior executives.
	Altnagelvin Hospital	Partial disclosure by all senior executives.
	Belfast City Hospital	Full disclosure by three senior executives. Consent to disclosure withheld by five senior executives.
	Causeway	Partial disclosure by one senior executive. Consent to disclosure withheld by seven senior executives.
	Craigavon Area Hospital Group	Full disclosure by one senior executive. Consent to disclosure withheld by eight senior executives.
	Craigavon & Banbridge Community	Consent to disclosure withheld by all senior executives.
	Down Lisburn	Partial disclosure by one senior executive. Consent to disclosure withheld by nine senior executives.
	Foyle	Full disclosure by one senior executive. Consent to disclosure withheld by six senior executives.
	Greenpark Healthcare	Consent to disclosure withheld by all senior executives.
	Homefirst Community	Partial disclosure by one senior executive. Consent to disclosure withheld by nine senior executives.
	Mater Infirmorium	Partial disclosure by all senior executives.
	Newry & Mourne	Consent to disclosure withheld by all senior executives.
	North & West Belfast Community	Full disclosure by one senior executive. Consent to disclosure withheld by nine senior executives.
	NI Ambulance Service	Partial disclosure in incorrect format.
	Royal Group of Hospitals & Dental Hospital	Partial disclosure by all senior executives.
	South & East Belfast Community	Partial disclosure by one senior executive. Consent to disclosure withheld by four senior executives.
	Sperrin Lakeland	Full disclosure by seven senior executives. Partial disclosure by four senior executives.
	Ulster Community & Hospitals Trust	Partial disclosure by all senior executives.
	United Hospitals	Partial disclosure by six senior executives. Consent to disclosure withheld by two senior executives.

For 2003-04 accounts only executive board members were required to disclose.

Key :

	Full Disclosure
	Partial Disclosure
	Non Disclosure

Disclosure of salary details within the 2004-05 Accounts **APPENDIX 3b**

(See Section 4)

	HPSS Body	Executives / Non-executives	Extract of Disclosure In Accounts *
Boards	Eastern Health & Social Services Board	Executives	Full disclosure by all executives.
		Non-executives	Full disclosure by all non-executives.
	Northern Health & Social Services Board	Executives	Consent to disclosure withheld by all executives.
		Non-executives	Full disclosure by all non-executives.
	Southern Health & Social Services Board	Executives	Full disclosure by all executives.
		Non-executives	Full disclosure by all non-executives.
	Western Health & Social Services Board	Executives	Full disclosure by all executives.
		Non-executives	Full disclosure by all non-executives.
HPSS Agencies	Central Services Agency	Executives	Full disclosure by all executives.
		Non-executives	Full disclosure by eight non-executives. Consent to disclosure withheld by one non-executive.
	NI Health Promotion Agency	Executives	Full disclosure by all executives.
		Non-executives	Full disclosure by all non-executives.
	NI Blood Transfusion Service	Executives	Consent to disclosure withheld by all executives.
		Non-executives	Full disclosure by all non-executives.
	NI Guardian Ad Litem Agency	Executives	Full disclosure by all executives.
		Non-executives	Full disclosure by all non-executives.
	NI Regional Medical Physics Agency	Executives	Full disclosure by all executives.
		Non-executives	Full disclosure by all non-executives.
	NI Medical & Dental Training Agency	Executives	Partial disclosure by all executives.
		Non-executives	Full disclosure by all non-executives.

* For 2004-05 accounts both executive and non-executive board members were required to disclose.

Key : Full Disclosure

Partial Disclosure

Non Disclosure

Disclosure of salary details within the 2004-05 Accounts
(See Section 4)

APPENDIX 3b
(continued)

	HPSS Body	Executives / Non-executives	Extract of Disclosure In Accounts *
HSS Trusts	Armagh & Dungannon	Executives	Full discosure by one executive. Partial disclosure by one executive. Consent to disclosure withheld by eight executives.
		Non-executives	Full disclosure by all non-executives.
	Altnagelvin Hospital	Executives	Full discosure by six executives. Partial disclosure by three executives. Consent to disclosure withheld by one executive.
		Non-executives	Full disclosure by all non-executives.
	Belfast City Hospital	Executives	Full discosure by two executives. Consent to disclosure withheld by five executives.
		Non-executives	Full disclosure by all non-executives.
	Causeway	Executives	Full discosure by two executives. Consent to disclosure withheld by seven executives.
		Non-executives	Full disclosure by all non-executives.
	Craigavon Area Hospital Group	Executives	Full discosure by one executive. Consent to disclosure withheld by six executives.
		Non-executives	Full disclosure by all non-executives.
	Craigavon & Banbridge Community	Executives	Full discosure by one executive. Consent to disclosure withheld by ten executives.
		Non-executives	Full disclosure by all non-executives.
	Down Lisburn	Executives	Partial disclosure by one executive. Consent to disclosure withheld by nine executives.
		Non-executives	Full disclosure by all non-executives.
	Foyle	Executives	Full discosure by two executives. Consent to disclosure withheld by six executives.
		Non-executives	Full disclosure by all non-executives.
	Greenpark Healthcare	Executives	Consent to disclosure withheld by all executives.
		Non-executives	Full disclosure by all non-executives.
	Homefirst Community	Executives	Full disclosure by all executives.
		Non-executives	Full disclosure by all non-executives.
	Mater Infirmorum	Executives	Full discosure by one executive. Partial disclosure by five executives.
		Non-executives	Full disclosure by all non-executives.
	Newry & Mourne	Executives	Consent to disclosure withheld by all executives.
		Non-executives	Full disclosure by all non-executives.
	North & West Belfast Community	Executives	Full discosure by two executives. Consent to disclosure withheld by eight executives.
		Non-executives	Full disclosure by five non-executives. Partial disclosure by one non-executive.
	NI Ambulance Service	Executives	Full discosure by one executive. Consent to disclosure withheld by four executives.
		Non-executives	Full disclosure by one non-executive. Disclosure withheld by five non-executives.
	Royal Group of Hospitals & Dental Hospital	Executives	Full disclosure by all executives.
		Non-executives	Full disclosure by all non-executives.
	South & East Belfast Community	Executives	Partial disclosure by one executive. Consent to disclosure withheld by nine executives.
		Non-executives	Full disclosure by all non-executives.
	Sperrin Lakeland	Executives	Full disclosure by four executives. Partial disclosure by three executives. Consent to disclosure withheld by three executives.
		Non-executives	Full disclosure by all non-executives.
	Ulster Community & Hospitals Trust	Executives	Full disclosure by one executives. Partial disclosure by twelve executives.
		Non-executives	Full disclosure by all non-executives.
	United Hospitals	Executives	Full disclosure by six executives. Consent to disclosure withheld by three executives.
		Non-executives	Full disclosure by all non-executives.

* For 2004-05 accounts both executive and non-executive board members were required to disclose.

NIAO REPORTS

Title	HCNIA No.	Date Published
2006		
Insolvency and the Conduct of Directors	HC 816	2 February 2006
Governance issues in the Department of Enterprise, Trade and Investment's Former Local Enterprise Development Unit	HC 817	9 February 2006
Into the West (Tyrone and Fermanagh) Ltd: Use of Agents	HC 877	2 March 2006
Department for Social Development: Social Security Agency – Third Party Deductions from Benefit and The Funding of Fernhill House Museum	HC 1901	9 March 2006
The PFI Contract for Northern Ireland's New Vehicle Testing Facilities	HC 952	21 March 2006
Improving Literacy and Numeracy in Schools	HC 953	29 March 2006
Private Practice in the Health service	HC 1088	18 May 2006
Collections Management in the National Museums and Galleries of Northern Ireland	HC 1130	8 June 2006
Departmental Responses to Recommendations in NIAO Reports	HC 1149	15 June 2006
Financial Auditing and Reporting: 2004 – 2005 General Report	HC 1199	21 June 2006
Collections Management in the Arts Council of Northern Ireland	HC 1541	31 August 2006
Sea Fisheries: Vessel Modernisation and Decommissioning Schemes	HC 1636	26 October 2006
Springvale Educational Village Report	HC 40	30 November 2006
Reinvestment and Reform: Improving Northern Ireland's Public Infrastructure	HC 79	7 December 2006
The Fire and rescue Training Service	HC 80	14 December 2006
2007		
Internal fraud in Ordnance Survey of Northern Ireland	HC 187	15 March 2007
The Upgrade of the Belfast to Bangor Railway Line	HC 343	22 March 2007
Outpatients and Missed Appointments and Cancelled Clinics	HC 404	19 April 2007
Good Governance – Effective Relationships Between Departments and their Arm's length Bodies	HC 469	4 May 2007