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Northern Ireland Audit Office

General Report on the Health and Social Care Sector in Northern Ireland – 2008

REPORT BY THE COMPTROLLER AND AUDITOR GENERAL
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Northern Ireland Audit Office

Report by the Comptroller and Auditor General for Northern Ireland

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General Report on the Health and Social Care Sector in Northern Ireland – 2008

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J M Dowdall CB
Comptroller and Auditor General

Northern Ireland Audit Office
10 June 2009

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Abbreviations

AfC	Agenda for Change
BSO	Business Services Organisation
CSR	Comprehensive Spending Review
C&AG	Comptroller and Auditor General
CFU	Counter Fraud Unit
CRL	Capital Resource Limit
CSA	Central Services Agency
DHSSPS	Department of Health, Social Services and Public Safety
DFP	Department of Finance & Personnel
EHSSB	Eastern Health and Social Services Board
EPES	Electronic Prescribing and Eligibility System
FHS	Family Health Services
GMS	General Medical Services
GP	General Practitioner
GPS	General Pharmaceutical Services
HSC	Health and Social Care
HSCB	Health and Social Care Board
HSS	Health and Social Services
NAO	National Audit Office
NFI	National Fraud Initiative
NHS	National Health Service
NIAO	Northern Ireland Audit Office
NHSSB	Northern Health and Social Services Board
PFI/PPP	Private Finance Initiative/Public Private Partnership
PCC	Patient and Client Council
PCCI	Primary & Community Care Infrastructure
PHA	Public Health Agency
PPV	Post Payment Verification
PSA	Public Service Agreement
RSS	Regional Supplies Service
RPA	Review of Public Administration
RQIA	Regulation and Quality Improvement Authority
SIC	Statement on Internal Control
SHSSB	Southern Health and Social Services Board
WHSSB	Western Health and Social Services Board

Section One:
Introduction

Section One: Introduction

1.1 Background

1.1.1 The financial audit of the accounts of the Health and Social Care (HSC) bodies in Northern Ireland became the responsibility of the Comptroller and Auditor General for Northern Ireland (C&AG) from 1 April 2003.

1.1.2 In 2007, the C&AG published his first General Report on the Health Sector[1]. This second report focuses principally upon the results of the audits of the 2007-08 accounts, but it also looks back to some of the important issues identified in the 2005-06 and 2006-07 audits.

1.2 The Scope of the Audit and this Report

1.2.1 The report covers the audits of 16 health bodies in 2007-08. These include all health and social services (HSS) boards (the boards), all health and social care (HSC) trusts and a number of agencies and special agencies established by the Department of Health Social Services and Public Safety (the agencies). The report also considers the audits of the 18 trusts in 2005-06 and 2006-07 which, from 1 April 2007, merged into the 5 new trusts. It does not cover the results of the audits of the Department of Health, Social Services and Public Safety (DHSSPS/the Department) or of some non-departmental public bodies and one executive agency sponsored by DHSSPS. A full list of the bodies covered is shown at Figure 1.

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

1.3 Overall conclusion

1.3.1 The Department and the HSC sector continue to make progress in delivering improved health and social care services. This report reflects a number of recent successes: maintaining financial balance in the new merged health & social care trusts in 2007-08; further embedding the structures and processes of effective corporate governance; delivering better healthcare; and implementing a number of major change initiatives throughout the HSC sector.

1.3.2 The challenge now is to build on these achievements. Financial stability is a key issue, with a number of HSC bodies reporting significant spending pressures which could jeopardise their financial positions in 2008-09. The financial risks around the delivery of major capital projects should also not be underestimated. Further integrating clinical governance arrangements with health bodies' corporate governance remains a pressing need.

1 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: 6 July 2007: NIA 66/06-07

Figure 1: Bodies in the Health and Social Care Sector covered by this Report

2007-08	2006-07 and 2005-06
Trusts	
Belfast HSC Trust	Belfast City HSS Trust Green Park HSS Trust Mater Infirmorum HSS Trust North & West Belfast HSS Trust Royal Group of Hospitals & Dental Hospital HSS Trust South & East Belfast HSS Trust
Northern HSC Trust	Causeway HSS Trust Homefirst Community HSS Trust United Hospitals HSS Trust
South Eastern HSC Trust	Down Lisburn HSS Trust Ulster Community & Hospitals HSS Trust
Southern HSC Trust	Armagh & Dungannon HSS Trust Craigavon Area Hospitals Group HSS Trust Craigavon & Banbridge Community HSS Trust Newry & Mourne HSS Trust
Western HSC Trust	Altnagelvin Hospitals HSS Trust Foyle HSS Trust Sperrin Lakeland HSS Trust
NI Ambulance Services HSC Trust	NI Ambulance Services HSS Trust
Boards	
Eastern HSS Board Northern HSS Board Southern HSS Board Western HSS Board	Eastern HSS Board Northern HSS Board Southern HSS Board Western HSS 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	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

Section One:
Introduction

Progress is also necessary to improve the health of the people in Northern Ireland, particularly in reducing the current levels of smoking and obesity.

1.3.3 Perhaps most fundamental is the need to press ahead with the major change programmes of recent years. Some of these remain ongoing: the second phase of structural reorganisation arising from the Review of Public Administration, involving the dissolution of the health and social services boards and the creation of the regional health and social care board and other regional bodies, and the merger of some agencies, took place from 1 April 2009. Others, such as new contracts for GPs and consultants, are now well established. Completing and bedding in these changes is central to delivering the Department's plans for better health and social care. It will be important also to determine the benefits of these health service changes to patients and the wider public, so as to inform future change planning in other parts of the public sector.

Section Two:
Performance

Section Two: Performance

2.1.1 The Department requires that Health and Social Care (HSC) bodies meet a number of financial targets each year, and that they disclose their financial performance in their annual reports. Some of these targets are statutory, while others represent best practice.

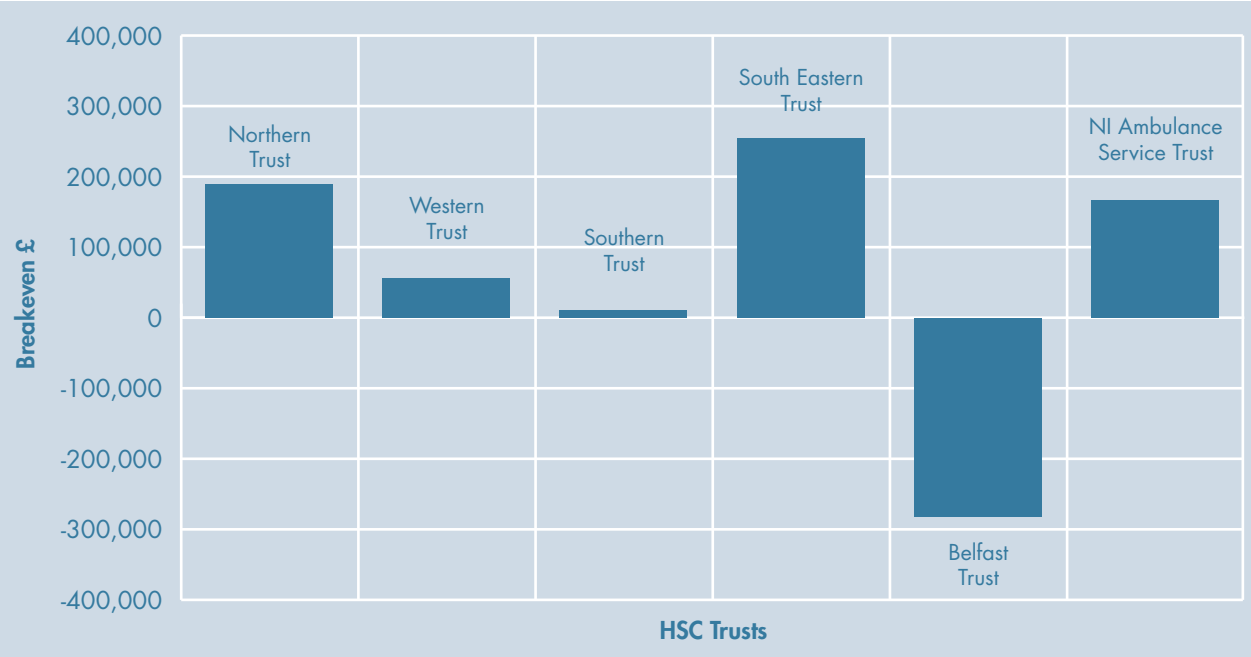
2.1.2 This section provides an overview of health bodies' financial and operational performance in 2007-08 and includes some references to financial performance in 2005-06 and 2006-07.

Overall financial performance

2.2.1 Trusts are required by statute to ensure that their income is sufficient to meet their expenditure taking one year with another - the break-even duty[2]. An explanation must be provided in the accounts if a variance from break-even of greater than 0.5 per cent of turnover is achieved. The Department also requires that agencies and boards conform to the general requirement of good financial management and specific targets have been established for these bodies to break even on their income and expenditure account each year.

2.2.2 Figure 2 sets out the financial results achieved by HSC trusts in 2007-08. From this, it will be seen that only one trust failed to achieve break-even in 2007-08: Belfast Health & Social Care Trust reported a deficit of £281,000, well within the limits of 0.5 per cent of its turnover of

Figure 2: Trusts' financial outturns 2007-08



Source: HSC trusts

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

£1,083m. Other trusts reported surpluses of between £11,000 and £254,000 and the aggregate position across the six trusts in 2007-08 was a surplus of £395,000. This reflects a high degree of effort from senior management and staff to build financial stability in the new merged trusts established in April 2007, a task made even more challenging by the underlying final financial positions of some of the predecessor organisations. For example, Sperrin Lakeland Trust returned a deficit of £3.36m in 2006-07. Despite this inherited position the new Western Health & Social Care Trust reported a surplus of £56,000 at 31 March 2008.

2.2.3 Trusts' management of their finances appears, at a fundamental level, to be successful. Certainly, trusts in Northern Ireland have met their break-even duty more consistently than trusts in England in recent years. Twenty one percent of National Health Service (NHS) trusts reported deficits in 2006-07, when Sperrin Lakeland, South & East Belfast and Homefirst Community were the only HSS[3] trusts in deficit. In 2005-06, 30 per cent of NHS trusts were in deficit, while only two HSS trusts (Sperrin Lakeland and Newry & Mourne) reported deficits. However, the different requirements of the NHS and HSC financial regimes may make it difficult to compare financial break-even performance directly. In the NHS, break-even is considered after the impact of any in-year financial provisions: for HSC trusts, the impact of provisions is not taken into account.

2.2.4 The Department has held the view that if provisions were to be included as a factor in assessing financial performance, there could be major unplanned variations in spending year on year which might impact on patient services. In the NHS, the regime provides flexibility by allowing trusts to break even over a three year period, partly to cope with unplanned financial demands, but HSC trusts are required to break even each year. If provisions were included in the break-even calculation, four HSC trusts (Belfast, Western, South Eastern and NIAS) would have reported deficits between £617,000 and £1,157,000 in 2007-08.

2.2.5 Two boards, the Eastern Board and the Northern Board, returned small revenue deficits, including movements in provisions, in 2007-08 of £107,000 and £380,000 respectively. Each of these results was within an acceptable tolerance limit (in terms of percentage of turnover) in the view of the Department. The other boards returned small surpluses and the aggregate position across the four boards was a deficit of £163,000 – or some 0.006 per cent of total board income of £2.8bn. The Eastern Board has incurred minor deficits in each of the last five years and its deficit this year increased to the above figure from £47,000 at 31 March 2007. Agencies were able generally to contain their expenditure within their income this year, although deficits were returned by the Northern Ireland Medical & Dental Training Agency (£135,000) and the Northern Ireland Guardian Ad Litem Agency (£61,000).

3 Prior to 1 April 2007, trusts were designated as Health and Social Services (HSS) trusts

Section Two: Performance

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

- the Capital Resource Limit (CRL), a fixed annual capital spending limit for each trust, set by the Department;
- the commissioning administration ceiling (commissioning cost), a statutory target for the administrative costs at each board of commissioning healthcare from providers, set by the Department as a percentage of relevant income;
- management costs, a best practice measure of trusts' efficiency. All trusts are expected to maintain their management costs[4] within a ceiling of 5 per cent of relevant income; and
- the prompt payment policy, a best practice measure, applies to all HSC bodies[5]. No actual target for performance is set, but best practice suggests that 95 per cent of payments to creditors (measured by volume) should be made within 30 days.

2.2.7 Performance against these targets was generally sound. All trusts adhered to their CRL in 2007-08. Management costs were contained within the 5 per cent ceiling in five trusts, with only the Northern Ireland Ambulance Service Trust returning above this figure (6.3 per cent). The boards continue to drive down their commissioning costs, reporting costs as a percentage of relevant income of between 0.89 per cent (in the Eastern Board) and 1.45 per cent (in the Southern Board). All the boards met their targets in this respect.

2.2.8 The common exception to this performance was in compliance with the prompt payment policy. Only two bodies, the Health Estates Agency and the Northern Ireland Blood Transfusion Service, achieved the 95 per cent target, by volume (see Figure 3).

2.2.9 While some bodies came close to meeting the target - the Eastern, Northern and Western Boards achieved above 94 per cent, as did the Health Promotion Agency - the general picture is one of average compliance at around 90 per cent. This has been the case for some years. The Department has advised us that it continues to monitor the HSC's performance in compliance with the policy. However, clearly more needs to be done in HSC bodies to achieve the standard expected.

Operational performance

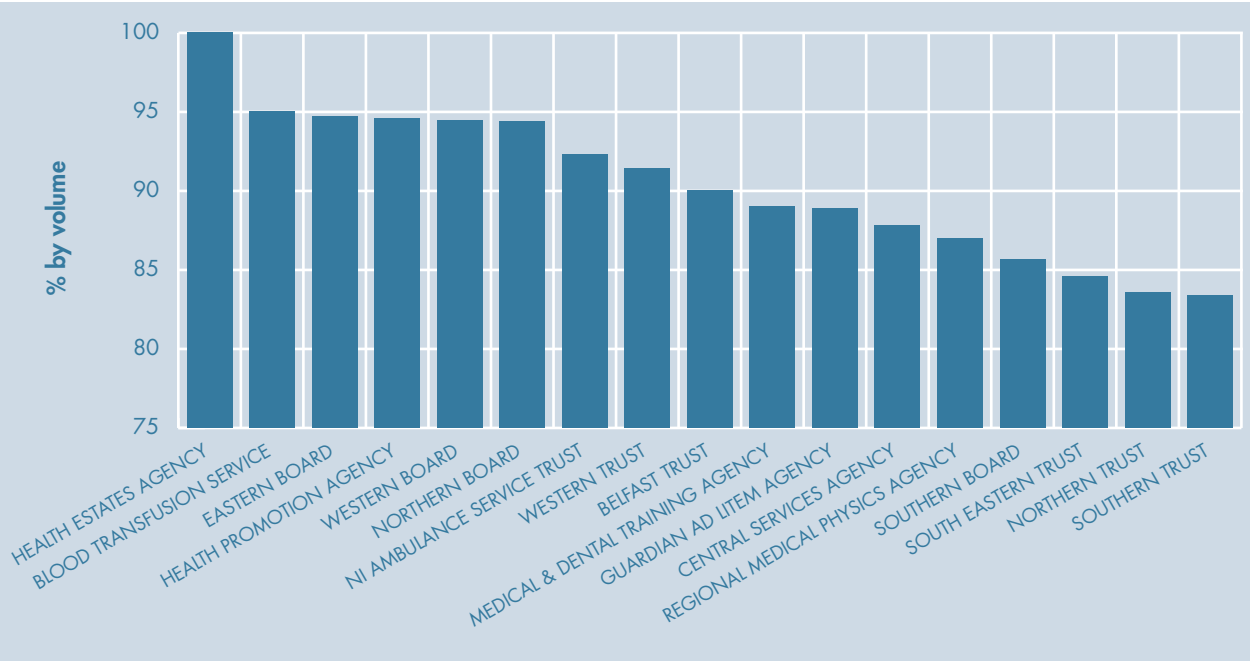
2.3.1 We published our report, The Performance of the Health Service in Northern Ireland in October 2008[6]. This examined the Department's success in using quantitative, time-limited targets to help drive improvement in health and social care services. The report looked at the performance of the HSC bodies in Northern Ireland against the range of Public Service Agreement health-related targets detailed in Priorities and Budget 2006-08 (the Direct Rule counterpart to the Programme for Government).

4 The calculation of management costs is based on the Audit Commission definition and reflected in Departmental guidance to trusts

5 The Department requires that all HSC bodies pay their non-HSC trade creditors in accordance with the Confederation of British Industry's Prompt Payment Code and associated Government Accounting rules, and that they disclose annually the extent to which they comply with these requirements

6 The Performance of the Health Service in Northern Ireland: NIAO, NIA 18/08-09, 1 October 2008

Figure 3: Prompt payment policy 2007-08



Source: HSC bodies

2.3.2 The picture of operational performance in health and social care services is one of marked improvement in access, quality and outcomes. There are some areas where progress may be falling short of initial expectations, particularly in relation to some public health issues. On the one hand, patients are waiting far less time for treatments and appointments in hospital and fewer people are dying from common conditions such as cancer and coronary heart disease. There have also been significant reductions in the prevalence of smoking and in unplanned births for teenage mothers. On the other hand, some groups of people continue to need more attention: too many manual workers are still smoking, some five per cent of the Primary 1 age group school children are obese, the suicide rate (albeit an unreliable indicator of health patterns) has been climbing; and the relatively limited focus on preventative care in oral health needs to be redressed.

Financial outlook

Revenue

2.4.1 Financial demands on HSC bodies continue. The budget allocation in 2008-09 provided more than £4.1bn for health and social care services in Northern Ireland. Nevertheless, trusts were predicting deficits throughout the early part of 2008-09; the Belfast Trust initially forecast a £36m

Section Two: Performance

shortfall, to be partially managed by an £18m efficiency programme which would have left the Trust needing to save, or agree additional funding of, a further £18m during the year. The Northern Trust was predicting a £6m deficit. The Western Trust planned to achieve break-even through comprehensive spending review and other efficiency savings of around £20m, and in so doing it would avert the potential repayment to the Department of the £3.36m deficit inherited from Sperrin Lakeland Trust, in two equal instalments, in 2009-10 and 2010-11. The South Eastern Trust initially forecast a deficit of around £5m. In the light of these forecasts, we were unable to provide positive assurances to the Department about these trusts' financial standing at the conclusion of the 2007-08 audits. However, the Department told us that it closely monitors the financial position of all HSC organisations on an ongoing basis and requires individual organisations to take corrective action where necessary in order to achieve the mandatory break-even. The most recent advice from the Department is that trusts' 2008-09 financial positions were substantially resolved and that all trusts were required to take whatever further actions were necessary to achieve break-even at the year end.

2.4.2 The position of the boards also appeared challenging. In what was the last year before the establishment of the Health and Social Care Board on 1 April 2009, three of the boards faced financial pressures from a range of sources and we were unable to provide positive assurances on their financial standing at 31 March 2008. The effects of elective care reform, in particular, were expected to be significant: in total, the boards reported a £38m funding shortfall to implement the changes necessary. The Southern Board also faced considerable financial demands but benefited from the capitation funding formula which reflected the growth of population in the area in recent years, and we were content with its financial standing in 2007-08. As with the HSC trusts, the Department monitors boards' financial performance on an ongoing basis and it expected each board to continue to achieve financial balance, in keeping with previous years. At the date of publication of this report, the audit of the 2008-09 accounts of HSC bodies had not been completed.

Capital

2.4.3 Modernising the infrastructure of the HSC sector remains a key priority for the Department. A capital programme is under way to renew many of the key facilities for health and social care across Northern Ireland, with a focus on investing in primary and community care to support the strategy of *A Healthier Future* and *Caring for People Beyond Tomorrow.* The capital budget for infrastructure across health and social care was £185m in 2007-08, including key projects such as Ulster Hospital Redevelopment Phase A, Downe Enhanced Local Hospital and Altnagelvin Area Hospital Redevelopment. In addition, investment was also made in other significant projects to build new and enhanced hospital facilities in Enniskillen and Omagh (expected to cost more than £450m, with the new Enniskillen hospital project reaching financial close)

and the new regional picture archiving and communications project (a managed equipment services contract funded through revenue, but expected to cost more than £54m over the next ten years).

2.4.4 Perhaps most significant, the Primary & Community Care Infrastructure (PCCI) programme aims to provide a step change in services and facilities for local communities, allowing the transfer of some services out of hospitals into community care settings and facilitating the delivery of the new enhanced primary care services envisaged in the General Medical Services (GMS) contract. The PCCI programme is estimated to cost £1.5bn over ten years. The first facilities built under the PCCI programme have been completed.

2.4.5 The risks involved in delivering capital projects on this scale are immense. The Department, through the Health Estates Agency, has established project management arrangements to manage completion of capital schemes. Trusts are also required to comply with common programme management requirements for infrastructure investment through the Strategic Investment Groups established for each trust. A PSA target was agreed for 2008-09:

Trusts should ensure that, throughout 2008-09, they comply with all agreed schedules for the completion of business cases, project procurement, and project delivery in respect of high priority, strategic projects (Investment Programme, PSA 10.1).

2.4.6 We remain engaged with the Department in reviewing technical accounting advice on PFI/PPP projects and in considering the value for money of the proposals. For example, we recently published a report on the PFI Laboratory and Pharmacy Centre at Altnagelvin[7] and the Public Accounts Committee subsequently issued recommendations for further action[8].

2.4.7 We will keep a close watch on the progress of the HSC capital programme in the coming year and may report on developments in our next general report.

7 Delivering Pathology Services: The PFI Laboratory and Pharmacy Centre at Altnagelvin, NIAO, NIA 9/08-09, 3 September 2008

8 Report on Delivering Pathology Services: The PFI Laboratory and Pharmacy Centre at Altnagelvin, PAC 16/08/09R, 6 November 2008

Section Three:
Health Service Initiatives

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Health Service Initiatives

3.1.1 The period from 2005 to 2008 has seen the implementation of a number of significant policy developments in the health sector in Northern Ireland. Some of these initiatives, and the changes they bring, are still in progress: others are now embedded. All of them present significant challenges for HSC bodies. In this section we discuss the progress, and emerging impacts, of:

- the Review of Public Administration (RPA) in health;
- new consultants' contracts;
- the new contract for General Medical Services (GMS); and
- Agenda for Change.

Review of Public Administration

3.2.1 The Review of Public Administration's two reports, in November 2005 and March 2006, recommended a radical overhaul of the public sector in Northern Ireland. In response, the health sector has embarked on a series of major structural changes:

- replacing 18 of the 19 health trusts with 5 new trusts;
- winding up the 4 health boards and replacing them with a single, regional health and social care board;
- creating a new regional agency for public health and social well being;
- leaving the 19th trust, the Northern Ireland Ambulance Service Trust, and a number of other health agencies to continue to operate independently; and
- merging a number of other health agencies.

3.2.2 The new merged trusts came into operation from 1 April 2007 as planned. We discussed the generally positive financial and operational performance of the new trusts in their first year in Section 2 of this report. That these results were achieved in the face of the challenges encountered by such new organisations - of integrating the diverse financial and operating systems of the predecessor trusts; of maintaining a skilled and committed workforce in a time of change and uncertainty; and of creating a unified organisational culture in the new trust - reflects well upon all those involved. Nevertheless, further work remains to be done in some bodies, for example, in the integration of accounting and other functions on single sites to enhance efficiency. Vigilance will be required in the coming year to deal with these and other challenges as the trusts move beyond the initial implementation stage of the reforms into a stage of consolidation, with the objective of securing consistently improved services. The experience of NHS reforms in England suggests that this could take some time.

3.2.3 Progress in restructuring the health boards has not been as swift. Originally planned for 1 April 2008, the dissolution of the four health boards and the creation of the new regional board took place on 1 April

2009 with The Health and Social Care (Reform) Bill coming into operation on that date.

3.2.4 A number of new health agencies were also established on 1 April 2009, following the dissolution of existing organisations. Expected to be particularly significant to the health sector are: a new regional business services organisation, taking on most of the functions of the Central Services Agency and some functions previously housed elsewhere in the health sector; a new regional agency for public health and social well-being, which took on the functions of the Health Promotion Agency and some functions previously housed elsewhere; and a new inspection agency formed from the merger of the Regulation and Quality Improvement Authority and the Mental Health Commission.

3.2.5 The benefits of RPA will inevitably take time to emerge. We will consider the merits of undertaking a value for money study once all the changes are implemented. Even at this stage, the costs of RPA are considerable. For example, more than £16m was spent in compensating senior officers for the loss of their posts during the trusts' reconfiguration, and £90m has been set aside by the Department to meet the total redundancy and early retirement costs of RPA in health.

Consultants' contracts

3.3.1 The new consultants' contract, introduced in 2004-05, is the first new contract negotiated for NHS consultants since the inception of the health service in 1948. Its purpose is to provide a more effective system of planning and timetabling consultants' activities:

- allowing trusts to plan consultants' work around the needs of patients;
- limiting consultants' working hours in line with the European Working Time Directive;
- ensuring that the health service has first call on consultants' time and reducing conflicts around private practice;
- making it easier to recruit and retain consultants in the NHS; and
- increasing rewards for consultants.

3.3.2 The impact of the new contract has been felt across the UK. The new contract cost the NHS £715m in its first three years in England, £150m more than was estimated. Consultants earned, on average, 25 per cent more in this period than in the previous three years while working similar or less hours than before. The National Audit Office concluded that the contract was not yet delivering the value for money to the NHS and patients that had been expected.[9]

3.3.3 A study by the King's Fund in 2006 identified a number of key issues. There was a considerable variation in the approach to implementing the new contract between NHS trusts. The scale of the task was underestimated; the contract was a

9 Pay Modernisation: A New Contract for NHS Consultants in England (NAO, April 2007)

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complex one and national guidance was late, unclear or non-existent. There was little reported evidence that the new contract led to any widespread changes in consultants' working patterns or influence on patient care, and no significant direct impact on patterns of consultants' private practice in London was noted.[10]

3.3.4 In Scotland, the new contract cost an extra £235m in its first three years, increasing the consultant pay bill by 38 per cent. Audit Scotland concluded that:

- the Scottish Executive Health Department significantly underestimated its cost, making it difficult for employers to budget for it properly;
- while the new contract offered the opportunity to improve patient care, it was not yet being used to its full potential; and
- clear evidence of the contract's benefits to the NHS in Scotland had yet to emerge.[11]

3.3.5 We are unaware of any evaluation of the consultants' contract in Northern Ireland. The Department plans to include a study of its impact in its value for money audit programme. Given the findings of similar studies in England and Scotland, we would urge the Department to ensure that this is not delayed. In our view, it would be surprising if at least some of these issues were not also reflected in Northern Ireland.

General Medical Services

3.4.1 The new contract for delivering General Medical Services (GMS) came into effect on 1 April 2004. It was designed to bring about a range of improvements in primary care and to provide clear benefits to general practitioners (GPs), other healthcare professionals and patients, including:

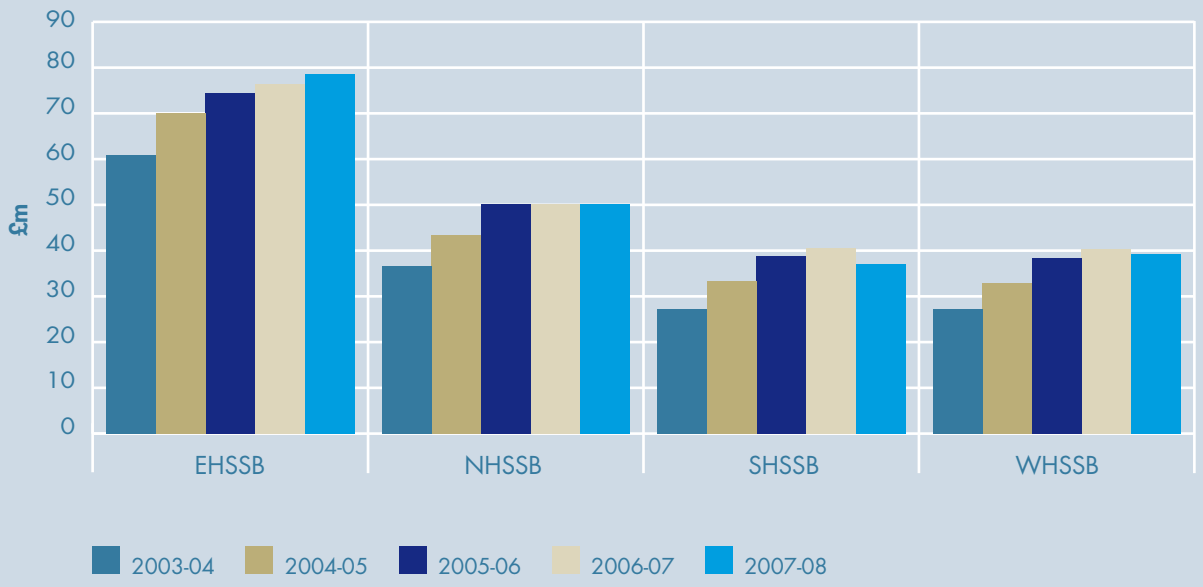
- better access to services;
- fairer funding;
- more efficient workload management, enabling GPs to opt out of providing some services (such as out of hours services);
- better management of chronic disease, by rewarding GPs for improved clinical standards; and
- better organisational standards, by rewarding GP practices for improved record-keeping and communication with patients.

3.4.2 The Boards have recorded a considerable increase in GMS spending since introducing the new contract (Figure 4).

3.4.3 Overall, GMS spending increased by 35 per cent between 2003-04 (the last year of the old GMS contract) and 2007-08, from £152m to £205m. The benefits of this increased expenditure to patients, in terms of improved access to better primary care services, have undergone an evaluation by the Department. A report in September

10 Assessing the New NHS Consultants' Contract (King's Fund, May 2006)
11 Implementing the NHS Consultants' Contract in Scotland (Audit Scotland, March 2006)

Figure 4: GMS expenditure 2004 to 2008



Source: HSSB accounts, 2003-04 to 2007-08

2007 identified that in the limited time that the contract has been in operation, a number of benefits for patients have been realised in terms of the range of services provided, greater consistency in the provision of care, better access to services, and improved management of their conditions. The report also noted that in many respects, however, the main benefits from the contract will take time to emerge. The Department advised us that it continues to work with other administrations to secure additional benefits relating to improving quality of services.

3.4.4 The benefits to GPs from the new contract are clear. In January 2007 the Minister for Health in Westminster commented that GPs were earning more than expected under the new contract, admitting that neither she nor the British Medical Association had anticipated the volume of extra work that GPs would undertake to secure performance related payments. Figures from the NHS Information Centre show that the average GP salary was £106,000 in 2004-05, up 30 per cent on the previous year.

3.4.5 The story of out of hours care is particularly illustrative. In return for surrendering an average £6,000 a year, GPs were able to opt out of providing out of hours care (between 6.30pm and 8.00am weekdays and over the weekend). The Department told us that it has achieved £3.5m efficiency savings from the out of hours service and that proposals were being developed for a regional out of hours service which would include linkages with

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accident and emergency and urgent care services. Nevertheless, the costs of out of hours services were £6m in 2003-04, the last year of universal GP provision: by 2007-08 these had risen to £19.5m. A similar story was reported in England, where the costs of out of hours services were £392m in the first year, £70m more than anticipated. The Westminster Public Accounts Committee in March 2007[12] described the preparations for the new system as 'shambolic' and observed that only GPs had benefited from the new arrangements.

Agenda for Change

3.5.1 The Agenda for Change (AfC) encompasses a new pay system for all staff, except doctors and senior executives. Implementation of the new pay structure began at pilot sites in England during 2003, and from 1 December 2004 was rolled out across the NHS and HSC sector. The process has been intensive. All staff have either had their job matched to a benchmark job profile or where that has not been possible the job has been subject to job evaluation. Once a job is graded and checked for consistency a system of assimilation takes place by which the transfer from the old pay structure to the new pay structure is effected. Involving more than 60,000 health and social care staff in Northern Ireland, this procedure has taken some considerable time.

3.5.2 The Department set a number of deadlines for HSC bodies to complete the process. In March 2008, the Minister set a final deadline of 30 June 2008 for all staff to move to the new rates on the understanding that this was not the end of the process as the calculation of arrears could not be delivered within this timeframe. Accepting that progress was variable across the HSC sector, the Department instructed health bodies to include accruals for the costs of the AfC in the annual accounts, where staff had not yet completed the transfer and been paid the monies due as a result. The value of these accruals was considerable: at 31 March 2006, health bodies owed more than £57m to staff. Such debts were large enough to undermine effective financial planning, as health bodies predicted significant cost pressures arising from AfC which were not covered by initial funding allocations. Estimates of the shortfall in 2006-07 varied between £25m and £33m, but by 31 March 2007, health bodies owed £97m for AfC accruals. The impact on the morale of staff that had yet to be assimilated, at a time when RPA mergers were also being planned and implemented, should not be underestimated.

3.5.3 The Minister of Health announced in June 2008 that HSC employers had met his deadline and that with the exception of a small number of posts (around 200 which would require job evaluation), all other staff had been moved to the new rates of pay. More than a year after the initial deadline of 1 April 2007 set by the Department, the process was not complete, as staff had still to be paid any arrears owing, and arrangements established, for recovering

12 The Provision of Out-of-Hours Care in England, 16th Report (2006-07) of Committee of Public Accounts, February 2007, HC360

overpayments from the relatively small numbers of staff affected as a result of making incorrect estimates of amounts due.

3.5.4 Given the recent completion, we accept that it may take some time for the success of the AfC to become apparent. We anticipate that we will re-visit this issue in future reports.

Conclusion

3.6.1 The experience of implementing change in the health sector in Northern Ireland has some important lessons for those charged with reforming the public sector. We consider that the introduction of new consultants' contracts, the GMS contract and the Agenda for Change demonstrates a number of common issues, including the need to:

- provide timely, complete and accurate guidance from the sponsoring department, identifying key actions, monitoring progress and providing support to those implementing change;
- define expected outcomes in order to manage the risk of inconsistency in local implementation;
- identify baseline information with which to assess the benefits to service users before schemes are implemented nationally;
- establish realistic cost models, based on accurate and relevant data, to build budgets that properly reflect the financial impact of new schemes;
- set reasonable timescales for implementing major change projects; and
- follow up implementation with a comprehensive review and assessment of the benefits achieved in terms of service provided and the costs of implementing such changes.

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4.1.1 Governance is the system of accountability, to service users, stakeholders and the wider community, within which organisations lead and direct their activities to achieve their objectives. The Department has been concerned to promote good governance in HSC bodies for a number of years, prescribing codes of accountability and conduct and requiring the boards of HSC bodies to establish a system of internal control and to disclose its effectiveness in an annual Statement on Internal Control (SIC). Boards must focus not only on matters of corporate governance - financial management, risk management, internal and external audit arrangements - but also on clinical governance. Controls assurance standards, introduced in Northern Ireland in 2003, require HSC bodies to identify their risks in up to 22 areas of corporate and clinical governance and to report in the accounts on how effectively these risks are being managed.

4.1.2 This section evaluates the progress being made by HSC bodies in establishing effective governance. It comments on the disclosures in the SIC; controls assurance standards; the role of the audit committee; remuneration of senior employees; clinical governance issues; and considers the implications of these issues for HSC bodies' governance arrangements.

The Statement on Internal Control

4.2.1 The Statement on Internal Control sets out the risk and control issues facing the organisation and the ways in which it maintains and reviews the effectiveness of its internal control environment. The SIC must be signed by the Accounting Officer.

4.2.2 On the whole, HSC bodies have achieved considerable improvement in the quality of the published SICs in recent years. This is possibly a reflection of the improvements in the underlying processes for preparing the SIC: for example, reviews of the risk register have become a standing item on the agenda of committees and management teams and ongoing programmes of education and awareness training have been established. The result is greater openness and transparency in the contents of the SIC, particularly in disclosing specific control weaknesses and the actions taken in response. Where, during audit, we see a need for a control weakness to be divulged, along with the body's proposals to counter those weaknesses, we will encourage the body and its Accounting Officer to amend the SIC. A number of recommendations to this effect have been made in recent years. We have also encouraged the Department's Accounting Officer, in view of his overall responsibility for the HSC sector, to maintain his policy of revising the Department's SIC to take due account of those significant areas of control weakness, which have been disclosed in the SICs of individual HSC bodies.

Case study - Western Health & Social Care Trust

The Western Trust disclosed a number of significant internal control issues in the 2007-08 SIC. These included:

- the £3.4m deficit brought forward from its predecessor trust, Sperrin Lakeland and the discovery of additional liabilities of £0.4m during the year;
- payments for management consultancy under a contract awarded by the Sperrin Lakeland Trust of £76,000 in 2006-07, and further contract payments of £53,000 by the Western Trust, which did not meet Departmental guidance and were therefore unauthorised;
- specialist advisors' costs of £2.4m on capital projects, incurred with the Department's knowledge, which were nevertheless deemed to be outside of the business case approved by the Department of Finance & Personnel (DFP);
- the findings of an independent inquiry panel into the deaths of a patient and her daughter, highlighting significant failings in their care and protection;
- clinical governance risks in the Trust's acute hospitals; and
- the establishment of the Toner review into the Omagh house fire.

4.2.3 This level of openness is increasingly common and must be commended, but it is not yet universal; a point made by the Department's Accounting Officer in a letter to all health bodies in May 2008. A minority of HSC bodies continue to disclose much in the way of their systems and procedures for establishing internal control and managing risk, but little in the way of the control weaknesses and risks identified as a result of these processes. This is not what the Department expects of them and is not considered to be good practice. The Audit Commission has identified two principal drivers of citizens' trust in public bodies: the quality of services that individuals and their families receive; and how open and honest organisations are about their performance, including their willingness to admit to and learn from their mistakes.[13] We believe that more transparency about the operations and performance of individual bodies across the HSC will lead to greater public trust in these bodies. With this in mind, we expect and encourage all HSC bodies to disclose significant internal control weaknesses, where they exist, in the published SIC.

Controls assurance standards

4.3.1 Controls assurance standards focus on key areas of risk within the HSC sector and provide a vehicle for Accounting Officers to report the extent to which these risks are being managed effectively. HSC bodies are required to self assess their level of compliance with the standards and report this annually to the Department. In 2007-08 the standards covered 22 areas, although not all were applicable to every organisation.

4.3.2 The results of these self assessments are shown in Figures 5 to 7.

13 Corporate governance, Audit Commission, October 2003

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Figure 5: Controls assurance compliance 2007-08

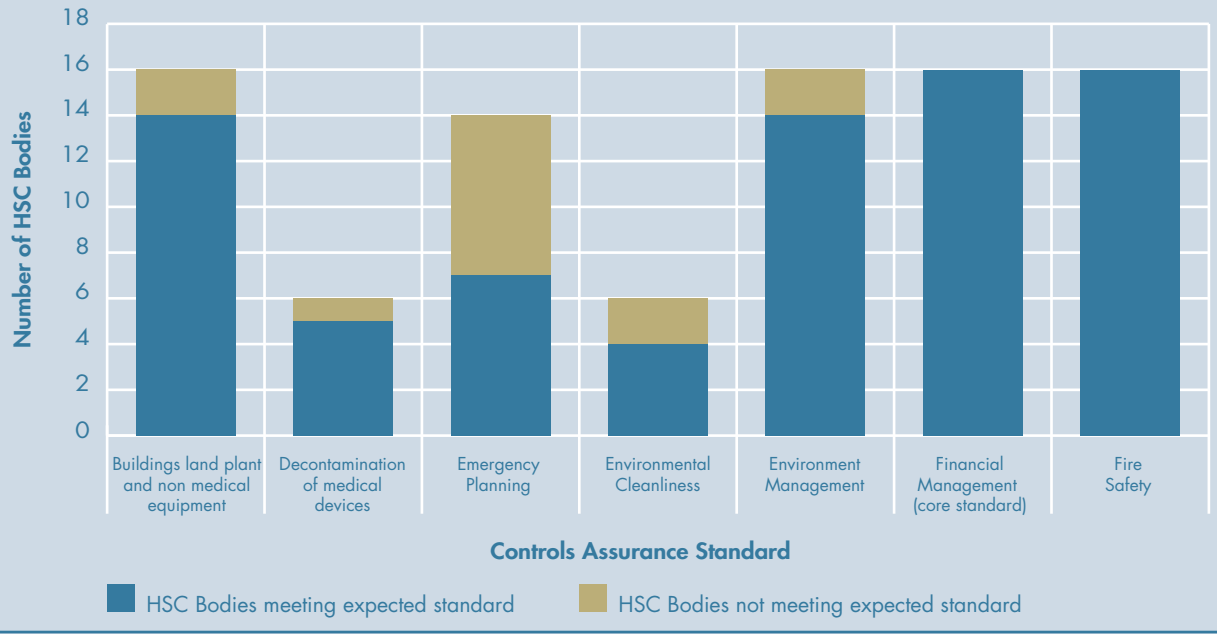


Figure 6: Controls assurance compliance 2007-08

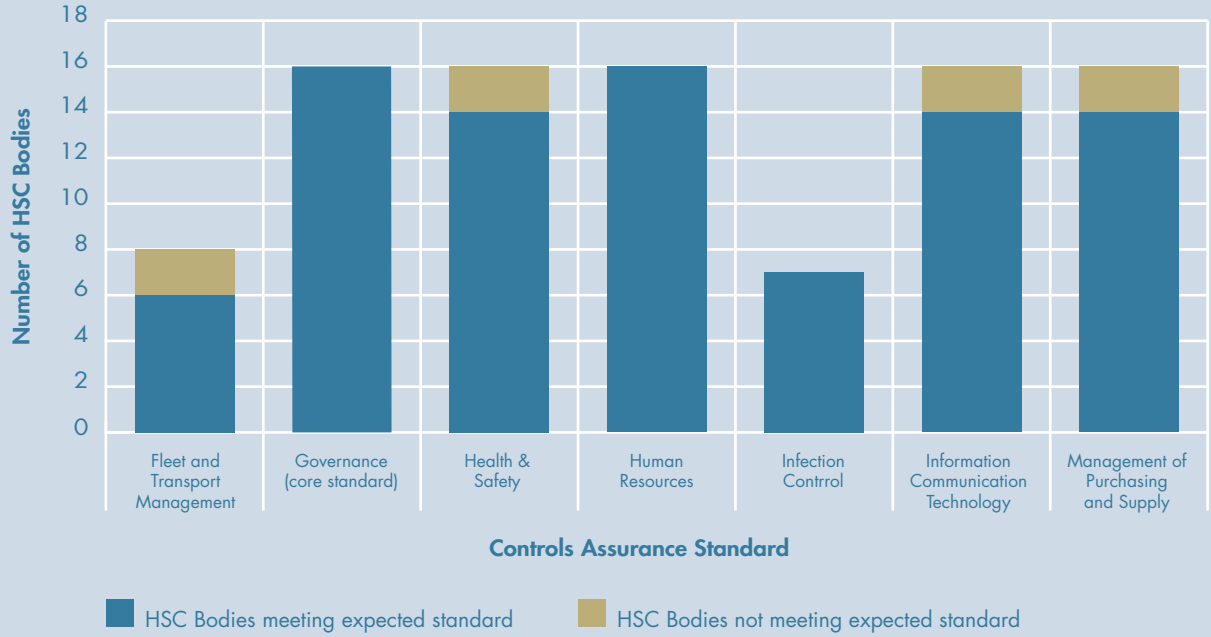
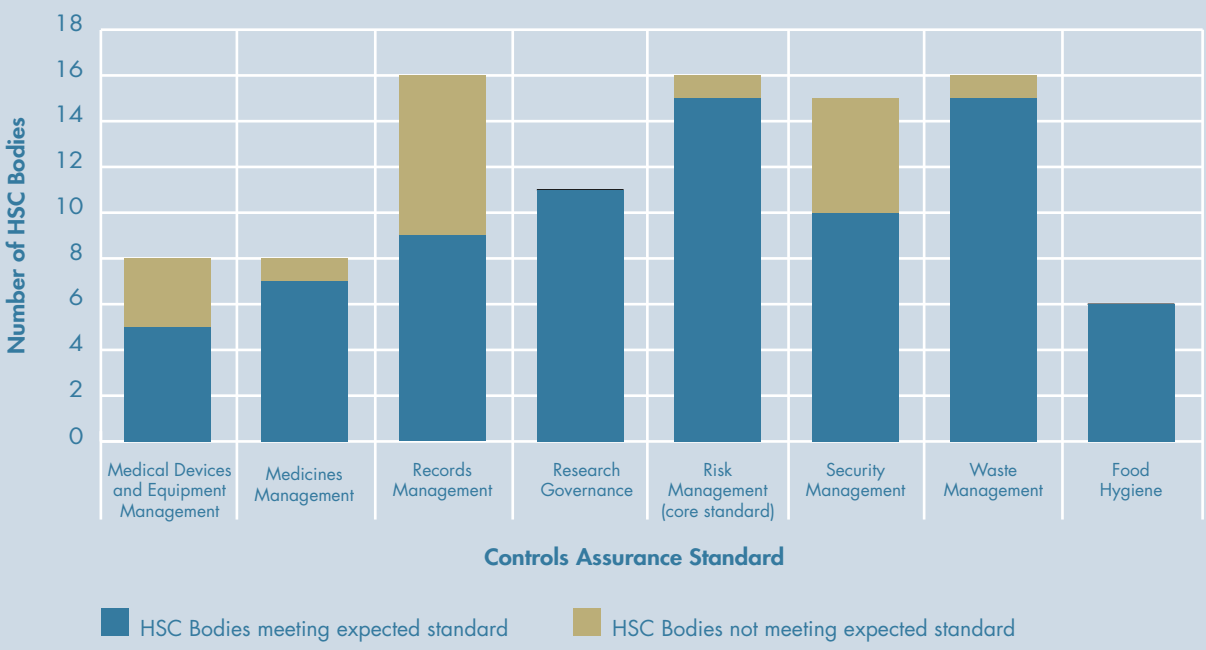


Figure 7: Controls assurance compliance 2007-08



Source: HSC bodies

4.3.3 These results reflect sound progress in implementing responses to these standard risks in HSC bodies. With one exception, substantive compliance has now been achieved against the core standards of risk management, financial management and governance – the exception being the Northern Ireland Blood Transfusion Service, which did not achieve substantive compliance with the risk management standard. Substantive compliance has also been attained by all bodies which were required to do so, in human resources, fire safety, infection control, research governance and food hygiene. More than 80 per cent of HSC bodies reached the required standard in environment management, health & safety and waste management.

4.3.4 There can be no room for complacency, however. More needs to be achieved, particularly in the areas of emergency planning, records management and environmental cleanliness. Neither should we forget that achieving compliance with the standard does not mean eliminating the risk. For example, HSC trusts achieved substantive compliance with the infection control standard, and four out of six were substantively compliant with the environmental cleanliness standard and the decontamination of medical services standard in 2007-08. Despite this, the Regulation and Quality Improvement Authority has recently reported that maintaining cleanliness continues to pose a significant challenge for Northern Ireland hospitals and healthcare associated

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infections remain a problem. Those responsible for governance in HSC bodies also need to recognise that substantive compliance is acknowledged when only 70 per cent of the optimum level of compliance is achieved, and managers should continue to seek to achieve higher percentages of compliance.

Audit committees

4.4.1 HSC bodies are required to establish an audit committee as a sub committee of the Board. As the corporate governance agenda has developed, audit committees are being delegated increasing responsibility for the oversight of disclosures relating to internal control.

4.4.2 We continue to be impressed by the level of challenge exercised by some audit committees in the health sector. For example, we have noted the following good practice:

- some audit committees engage in private discussions with the internal and external auditors, without the presence of HSC bodies' management. This is an important tool for building trust between the committee and auditors and is an integral part of the independence framework, guaranteeing the auditors' freedom to discuss a range of matters without apparent or actual management influence; and

- some committees have summoned managers to appear in order to explain delays in implementing audit recommendations.

4.4.3 The value of the audit committee, and the contribution of non-executives to developing the governance agenda in the HSC sector since the early 1990s, are now well-recognised and provide good exemplars for other parts of the public service. We also welcome the recent appointment of non-executives in central government, following the Higgs report in 2003 (the Department of Health, Social Services and Public Safety appointed its first non-executives in September 2006 and its Audit Committee is, as in the HSC sector, composed wholly of independent non-executives).

4.4.4 Notwithstanding the good work of audit committees, there remains scope to improve their performance. For example:

- there is some evidence that the independent challenge function is not fully appreciated by all non-executives. In some committees, non-executives appear to see their main function as protecting the Director of Finance from audit criticism; and

- there is an inconsistent approach to reporting fraud and irregularity, in that some committees receive this information while others do not. We are also unaware of any audit committee that receives reports on the quantity and substance of whistle blowing incidents. In our view, audit committees should receive such details (including fraud and irregularity suspected, under investigation or proven) to enable them to discharge their responsibilities effectively.

4.4.5 There is also an opportunity to develop and expand the audit committee role further, to bring it into line with the HM Treasury Audit Committee Handbook which was adopted formally in Northern Ireland in 2007[14] and promulgated to the HSC sector. For example:

- audit committees should receive the annual report of local counter fraud units, and agree counter fraud work plans each year. This represents a useful development in cementing a joined up approach throughout all areas of governance;
- the audit committee should produce an annual report for the board, setting out how it has achieved its terms of reference for the year. This report would be in addition to the annual statement of assurance on internal control provided by the committee to the Accounting Officer; and
- audit committees should assess their own performance. The National Audit Office has published a self-assessment checklist which audit committees should consider using.

Remuneration of senior employees

4.5.1 Since 2003-04 there has been an expectation, in view of their decision-making responsibilities, that senior employees of HSC bodies should disclose their salary and pension details in the accounts each year. In 2004-05, the disclosure requirements were extended to include non-executive directors. Compliance with this requirement has been variable: in 2005-06 and 2006-07, one quarter of executive and non-executive directors in the HSC sector withheld their consent to disclose some or all of this information.

4.5.2 The drive towards openness and transparency received a significant boost during 2006-07 from the intervention of the Commissioner of Information. In response to a complaint about the withholding of directors' consent at Newry & Mourne HSS Trust, the Commissioner decided that disclosure in the national interest outweighed the natural right to withhold the information required, unless there were exceptional circumstances. As a consequence, a much fuller disclosure was achieved in 2007-08: only 3 executives in the Northern Board withheld their consent to the release of information. Another 2 former executives of demised trusts, whose severance payments should properly have been reported in the accounts of the new merged trusts, also withheld consent.

4.5.3 Whilst these cases were properly assessed and supported by the boards of these bodies, that there should be three such exceptional cases in one organisation is, in the circumstances, curious. Nonetheless, this year's progress marks an important step towards transparency in respect of the remuneration of senior employees in the HSC sector. The standard clause which is now in the employment contracts of all HSC senior executive staff, stating that they are required to disclose any salary and pension details in the annual accounts, will

14 HSS F 43-2007, DAO (DFP) 07/07

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also assist this process. We will continue to monitor this issue and hope to see full disclosure by all senior employees in the 2008-09 accounts.

Clinical governance

4.6.1 The picture of governance in the HSC sector is one of systems and structures that are now well developed. The processes for good corporate governance appear well on the way to becoming embedded: financial management is generally sound; internal control functions well in most organisations; and audit committees are a familiar feature in the governance arrangements of HSC bodies. Uniquely in the public sector, however, HSC bodies' governance arrangements also encompass clinical and social care governance and it is here that there is evidence of the need for further improvement.

4.6.2 Certainly, the assessment of the controls assurance standards (referred to earlier in this report) suggests that HSC bodies have had more consistent success in establishing arrangements to manage the risks in corporate governance areas (for example, financial management, risk management, fire safety) than in some areas related to clinical and social care governance (such as decontamination of medical devices and medical devices and equipment management). Research by the Audit Commission in 2003 established that there remained some way to go before the corporate and clinical and social care governance agendas could be effectively integrated in the management of NHS trusts in England[15]. Consideration of the recent work of the Regulation and Quality Improvement Authority (RQIA) lends some support to this in the Northern Ireland context.

4.6.3 RQIA monitors and inspects the availability and quality of health and social care services in Northern Ireland to ensure these are accessible, well managed and meet the required standards. The Authority carries out regular inspections, including incident reviews and investigations. These have identified weaknesses in HSC bodies' arrangements for clinical and social care governance.

4.6.4 In its recent overview report on clinical and social care governance arrangements RQIA focused on two themes across all health boards, trusts and agencies: corporate leadership and responsibility; and safe and effective care.[16] The review found that while clinical and social care governance arrangements were in place, there was a lack of integration of these within the overall governance arrangements. The main challenge lies in the full implementation of new systems within the reconfigured health and social care trusts. Other recent reviews, such as the report on arrangements for the prevention and control of *clostridium difficile* in trusts, have developed this issue. In particular, there is a pressing need to harmonise the array of policies and procedures inherited from predecessor organisations in the new, merged trusts.

4.6.5 The Department told us that proposals have been drawn up for how it will assess

15 Corporate governance (Audit Commission, October 2003)
16 Review of Clinical and Social Care Governance Arrangements in Health and Personal Social Services Organisations in Northern Ireland (RQIA, February 2008)

the performance of the HSC in relation to Safety & Quality and Performance & Service Improvement. These delineate responsibilities between the Department, the Regional Board and the Regional Agency and give a role to RQIA and the Northern Ireland Safety Forum. Once these arrangements become fully embedded, the Department expects that they will have a significant impact in improving clinical and social care governance within the HSC sector.

4.6.6 It is clear that clinical and social care governance arrangements require continued focus from leaders and managers in the HSC sector to improve the connection between the policies and procedures adopted by organizations and what actually happens in the care giving setting (wards, clinics, people's homes). We will continue to monitor progress.

Section Five:
Procurement

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5.1.1 After staff costs, the biggest expense for HSC bodies lies in the procurement of goods and services. Central purchasing arrangements operate within the HSC and all bodies are encouraged to make use of centrally negotiated contracts and regional purchasing expertise through the Regional Supplies Service (RSS) located within the Central Services Agency. The arrangements for good governance in procurement are therefore well established: nevertheless, our audit work regularly identifies examples of poor practice. In particular, we have found:

- significant departures from the normal procurement processes through the use of CF61 forms (now restyled as SS50s);
- non-compliance with established procedures in the use of consultants; and
- insufficient regard for value for money in the procurement of legal services.

We discuss each of these below.

Use of CF61 forms

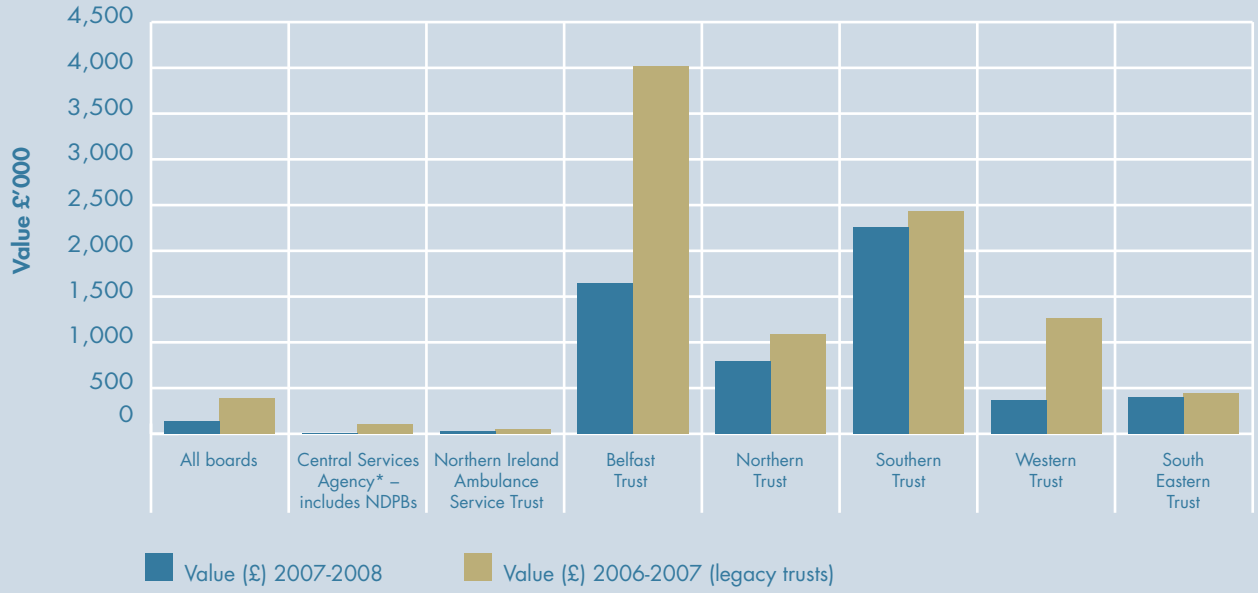
5.2.1 HSC bodies have the right to opt out of the normal procurement processes where circumstances dictate. Most frequently, this is due to preference for a particular item or supplier; for example, a particular brand or model of equipment may be necessary to ensure compatibility with existing equipment or for other operational necessity reasons. In all cases of opt out, a CF61 form must be completed and authorised by the Chief Executive justifying this method of procurement. A review of the use of CF61s by HSC bodies in 2006-07 and 2007-08 shows a wide variation in their use (Figure 8).

5.2.2 Overall, the use of CF61s shows a marked decrease in 2007-08, probably due to the merger of trusts at 1 April 2007 which may have prompted closer scrutiny of variant procedures and a more assertive challenge from the newly appointed directors of finance. Goods and services valued at £5.6m were procured this way on 396 occasions, compared to £9.8m in 2006-07 on 761 occasions. While the majority of bodies make little or no use of CF61s, a minority appear to use them routinely: the Southern Trust, most notably, spent £2.2m in this way in 2007-08. We understand that RSS has collaborated specifically with the Trust on this issue to increase awareness of the wider implications of procuring through CF61s.

5.2.3 There is no fundamental irregularity in the use of these arrangements, although HSC bodies are expected to provide satisfactory explanations on each submission to RSS as to why the competitive tendering processes have been overridden. Our review identified 18 cases in various bodies during the six-month period, October 2007 to March 2008, with a value of £89,000, where no satisfactory explanation was provided.

5.2.4 The Comptroller & Auditor General is required to give a regularity opinion on the RSS to all health bodies that use its services. Our review of RSS processes

Figure 8: Use of CF61s



Source: Regional Supplies Service

and procedures concluded that it had substantively complied with the relevant legislation and regulations in its central purchasing transactions in 2007-08. Where procurement was initiated by HSC bodies using CF61s, however, no opinion on the regularity of this expenditure could be formed. The significant use of CF61s, therefore, led to a qualification in the regularity opinion in respect of expenditure on these transactions through RSS.

5.2.5 Whilst we welcome the reduction in the number and value of goods and services procured using this process, we are concerned that the level of usage is still very high, particularly at the Southern Trust. We would urge the Department and HSC bodies to review their practices in this area and to question more closely, the justification for disregarding best procurement practice. We will continue to monitor this issue.

Use of consultants

5.3.1 We qualified the regularity opinion on the accounts of the Western Health & Social Care Trust in 2007-08 on two grounds:

- payments for management consultancy under a contract awarded by the Sperrin Lakeland Trust of £76,000 in 2006-07, and further payments of £53,000 by the Western Trust on the same contract, which did not meet Departmental guidance; and

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- specialist advisors' costs of £2.4m on capital projects, incurred with the Department's knowledge, which were nevertheless deemed to be outside of the approved business case.

Both these issues were disclosed in the Trust's Statement on Internal Control, discussed earlier in this report.

5.3.2 Management consultants were engaged by the Sperrin Lakeland HSS Trust in 2006-07. The work performed straddled the 2006-07 financial year, when the Sperrin Lakeland Trust was the accountable body, and the 2007-08 financial year, when, after merger, the Western Health & Social Care Trust was the accountable body. The circumstances in which the consultancy was procured are unclear and no documentary evidence was made available to us to demonstrate that the appointment was in line with the regulations. A retrospective business case was submitted to DHSSPS for Department of Finance & Personnel (DFP) approval; however this was declined by DFP. This expenditure was, therefore, determined to be irregular.

5.3.3 In August 2005, the Sperrin Lakeland Trust was given business case approval to establish project management arrangements relating to the new South West and Omagh Hospitals capital developments under the Developing Better Services initiative. The approval covered two components; directly employed project staff and engagement of specialist advisors. In October 2006, an addendum to the original business case was submitted by Sperrin Lakeland Trust to DHSSPS detailing a requirement for further funding to meet project management costs. This addendum was revised and updated during 2007-08 in response to emerging issues. The Western Trust continued to use these project management arrangements during 2007-08 while awaiting business case approval. The Trust was advised that the business case addendum had been approved by DFP for prospective project management costs from January 2008, but that this approval did not retrospectively cover expenditure incurred on specialist advisors between October 2006 and December 2007. Consequently, the Trust incurred £2.4m of expenditure on specialist advisors without specific business case approval.

5.3.4 It is important to note that this situation was largely beyond the control of the Western Trust, reflecting decisions taken previously within the Sperrin Lakeland Trust. The Department has acknowledged that the actual expenditure incurred was fully justified, legitimate and necessary, and the overall expenditure on project management was contained within the Trust's Capital Resource Limit allocation. Nevertheless, it remains technically beyond the regulations. We also qualified the regularity opinion on the Department's Resource Account in 2007-08 because of this.

Legal services

5.4.1 The Directorate of Legal Services (DLS), part of the Central Services Agency (CSA) was the only provider of legal services to NI health bodies until 1994, when

the then Department of Health & Social Services decided that this provision should be market tested. Health bodies were advised that if they wished to market test their legal services they should be tendered to providers from a select list established by the Department on 1 April 1996. This was not compulsory. Legal services covered by the select list were wide ranging, but the majority of work tendered related to clinical negligence cases. Bodies choosing not to undertake tender exercises continued to receive services from CSA. Over a number of years, some of these bodies did hold tender exercises resulting in services remaining either with CSA, transferring to Brangam Bagnall & Co (which we discuss later in this report) or, in a small number of cases, being awarded to other providers.

5.4.2 The initial list was intended to have a life of three years, with the option to extend it for a further three one-year periods to 31 March 2002. A new procurement exercise was initiated in 2002, but collapsed in June 2005. In June 2006, the DHSSPS Board agreed that a further market testing exercise should be carried out for the procurement of legal services, but progress was slow and in August 2008 the Minister for Health announced that, in future, all HSC bodies should seek legal advice from the Directorate of Legal Services.

5.4.3 On 4 December 2008, the Comptroller & Auditor General submitted a memorandum to the Northern Ireland Assembly's Public Accounts Committee on Contracting for Legal Services in the Health and Social Care Sector. This was to inform the Committee in its deliberations on the C&AG's report on the fraud at Brangam Bagnall & Co.[17]. The memorandum identified a number of areas where the Department has not been proactive in ensuring that legal services, delivered on behalf of the HSC, demonstrably provide value for money. Amongst its key findings were:

- the Department had been exposed for a number of years to potential legal challenge with respect to the significant period over which the select list, created in 1996, has existed;
- until the impact of the Minister's announcement in August 2008, that all legal services would in future be provided by the Central Services Agency, one firm continued to provide legal services to six trusts and one board, despite the fact that it had never gone through any form of tendering process;
- the Department did not meet the timescale indicated to the Public Accounts Committee in September 2002, for the re-tendering of legal services; and
- detailed management information in respect of legal services had not been collated and issued to the health service since 2001-02.

5.4.4 In summary, there has been no tangible evidence that the market testing approach adopted in 1996 has resulted in either a better quality of legal services or reduced costs.

17 Brangam Bagnall & Co: Legal Practitioner Fraud Perpetrated against the Health and Personal Social Services, NIA 195/07-08, NIAO, 4 July 2008.

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5.4.5 Evidence on the Legal Services Memorandum was taken by the Public Accounts Committee on 4 December 2008, and the Committee issued its findings and recommendations on this, along with its recommendations on the Brangam fraud (see section 6.4), on 26 February 2009.[18] We urge the Department to take action to address these as a priority.

18 Report on Brangam, Bagnall & Co: Legal Practitioner Fraud Perpetrated Against the Health and Personal Social Services, PAC, 26/08/09R, 26 February 2009

Section Six:
Countering Fraud

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Countering Fraud

6.1.1 Fraud in the HSC sector is unacceptable. Every citizen in Northern Ireland is the victim of fraud in public services, but most of all it hurts the vulnerable members of society who tend to rely on these services more than others. It also deprives society of resources which could otherwise be used for better systems and better public services. Countering fraud should therefore be seen not as an end to itself, but as a means of making the best possible use of public resources. Any actual or suspected cases of fraud should be reported to the Department in line with its current guidance[19]. It is then the Department's responsibility to notify the C&AG.

6.1.2 The Department has established arrangements to prevent and detect fraud. The main structures in place within the health sector are:

- 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, Fraud Policy Statement, Fraud Response Plan, and a Sanctions and Redress Policy. The Department has also issued a number of circulars to support its Counter Fraud Strategy;

- the Department's Audit Committee, which provides a forum where fraud issues are raised and discussed;

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

- the boards' probity units, whose work is directed by policies agreed by the Regional Probity and Counter Fraud Steering Group; and

- the Counter Fraud Unit (CFU), established by the Department in 2001 and now located within the new Business Services Organisation. The CFU's role has been to tackle exemption fraud by members of the public and also, acting on behalf of the boards, to investigate cases of suspected and actual fraud involving practitioners.

6.1.3 This section considers the continuing efforts against fraud and corruption in the health sector, focusing on:

- the work of the Counter Fraud Unit (CFU);

- post payment verification arrangements;

- the C&AG's recent report on Brangam Bagnall & Co; and

- the National Fraud Initiative.

The Counter Fraud Unit

6.2.1 The CFU has a wide remit, including the provision of counter fraud advice to the Department and to HSC bodies and, on

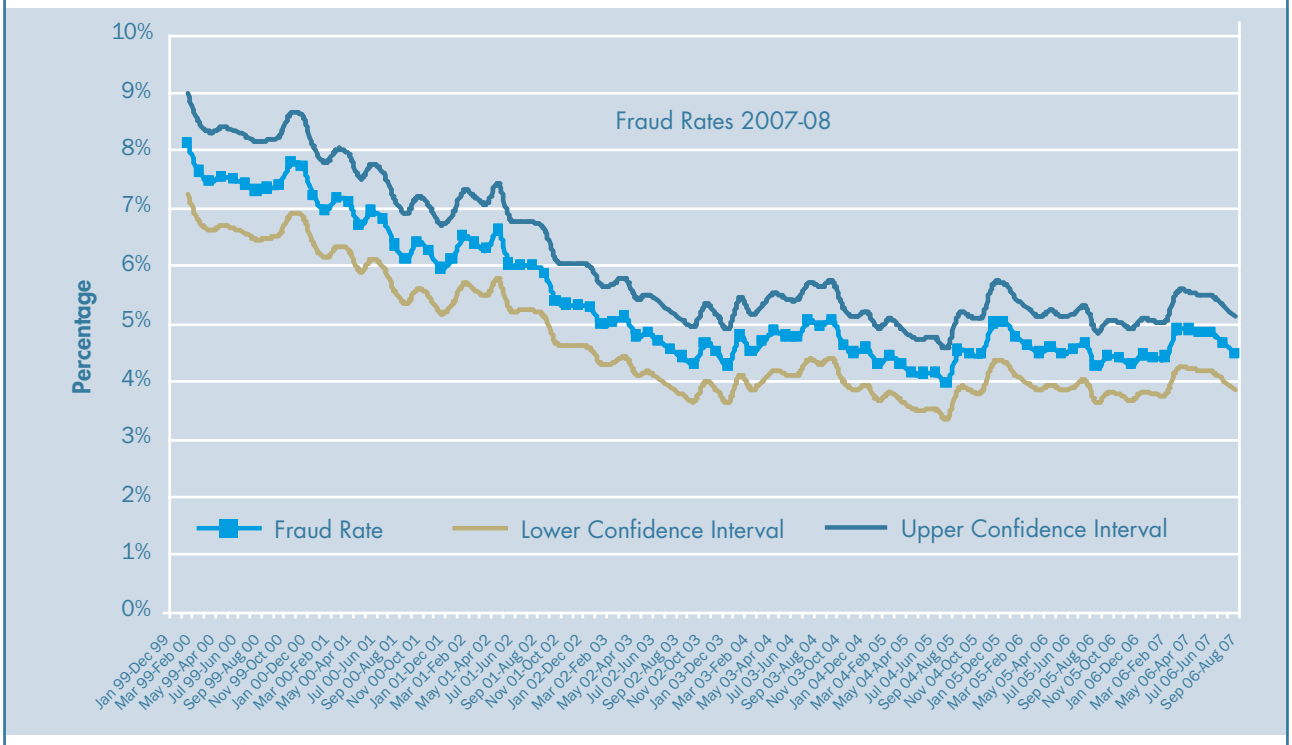
19 Circular HSS(F) 38/2005 – Revised Reporting Arrangements

behalf of the health boards, to tackle patient exemption fraud and conduct professional investigations into cases of suspected fraud involving practitioners and/or their staff. In relation to patient exemption fraud, the Unit has adopted a proactive approach in terms of a range of publicity campaigns, and a reactive approach through the verification of cases where patients claim to be exempt from statutory health charges. With the Minister's announcement at the end of September 2008 that prescription charges will be abolished, CFU's remit will undoubtedly change. The Department will be reviewing the policy relating to the types and number of exemption checks undertaken by CFU during the transitional period.

(a) Patient Exemption Fraud

6.2.2 Patient exemption fraud occurs where patients deliberately avoid paying for prescriptions and dental and ophthalmic treatments by making false claims for exemption, for example by fraudulently claiming that they receive qualifying social security benefits. CFU carries out a range of both random and targeted verification checks, where patients have claimed to be exempt from paying the relevant charges. This work, over a number of years, has helped drive down the incidence of fraud (see Figure 9, which shows a 12-month moving average).

Figure 9: Fraud rates 2007-08



Source: CFU Annual Report 2007-08

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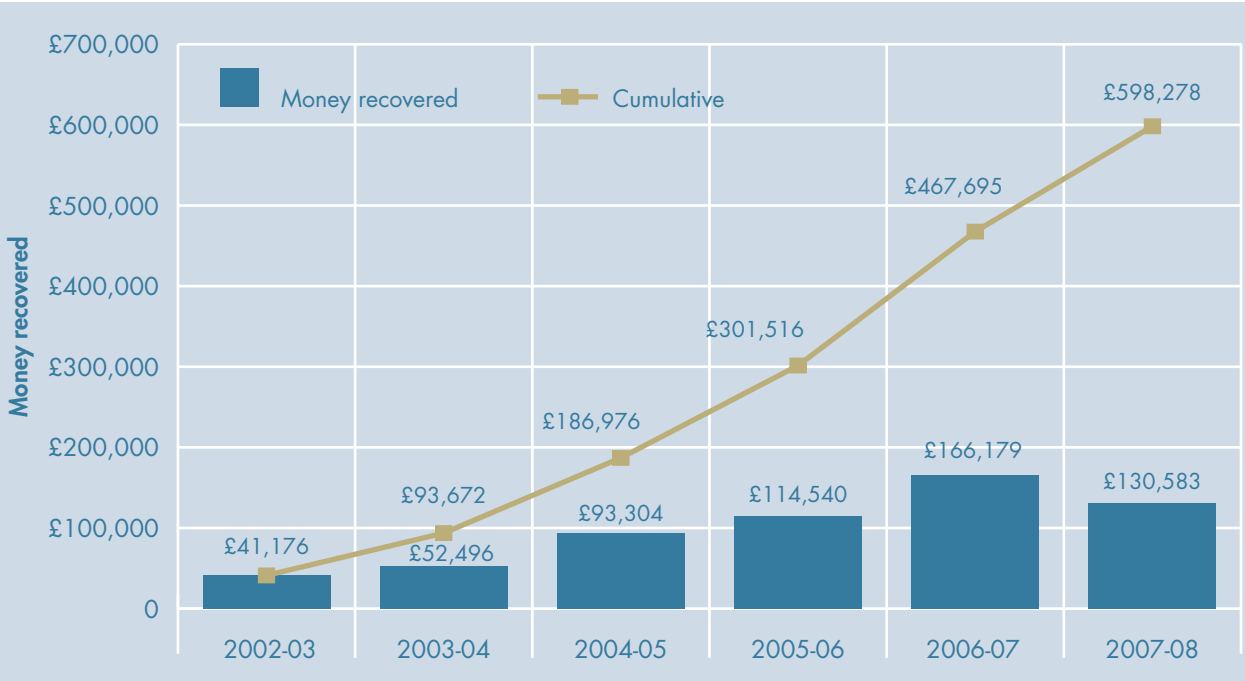
Countering Fraud

6.2.3 The 'best estimate' for the level of patient exemption fraud for 2007-08 was £9.9m, with an estimated fraud rate of 4.5 per cent. This compares with an estimate for 1999-2000 (rebased to take account of increases in prescription volume and cost) of £19.7m and a fraud rate of 8.14 per cent. This represents a reduction over the period 1999-2000 – 2006-07 of some 49.7 per cent. Overall, cumulative reductions in the estimated value of fraud for the same period amount to £57m.

6.2.4 CFU also recovered directly £130,000 from patients in respect of health service charges, penalty charges and surcharges in 2007-08 (Figure 10).

6.2.5 This is a substantial record of success. Nevertheless, the rate of fraud in patient exemption claims remains too high at 4.5 per cent. For this reason, the regularity opinion on the accounts was qualified by the C&AG at all four health boards in 2007-08. Perhaps more concerning, there is an emerging view that the CFU will be unable to secure further reductions in fraud beyond current levels given the current systems and resources within which it operates. The development of the Electronic Prescribing and Eligibility System (EPES), which maintains all claims to exemption from prescription charges on an electronic database, could have had a considerable impact on reducing exemption fraud even further, depending

Figure 10: Patient exemption recoveries 2002-03 to 2007-08



Source: CFU Annual Report 2007-08

on the availability of suitable resources in the CFU to undertake investigations. The EPES project, after undertaking a pilot stage, was due to be rolled out to 90 per cent of community pharmacies by September 2008. However, given the recent Ministerial announcement on the ending of prescription charges, the Department will need to review the purpose and use of EPES, its key objective having been, until then, to offer greatly increased functionality to the CFU in terms of carrying out exemption validation checks, thereby securing further substantial reductions in the level of exemption fraud.

(b) Contractor Fraud

6.2.6 The temptation to commit fraud, for a small number of family health services (FHS) contractors, will always exist. The CFU continues to undertake investigations, in conjunction with health board colleagues, into pharmacists, opticians, dentists and GPs and/or their staff, where suspicion of fraud exists. In 2007-08, investigations into practitioners resulted in total savings to the public purse of more than £1.4m:

- a detailed case involving claims made for the provision of ophthalmic services was passed to the Public Prosecution Service;
- nine cases of drug propriety/generic miscoding by pharmacists resulted in the recovery of over £300,000; and
- recoveries from dental practitioners amounted to £3,000.

6.2.7 At 31 March 2008, the Counter Fraud Unit's on-going casework included investigations involving dental, general medical and community pharmacy practitioners. The Unit is also working closely with the Police Service of Northern Ireland on a number of cases involving attempts by individual patients to fraudulently obtain prescription medicines.

(c) The Pharmaceutical Industry

6.2.8 Operation Holbein, the investigation into the alleged operation of a price-fixing cartel by a number of pharmaceutical manufacturers, secured out-of-court settlements of over £325,000 for the Department of Health, Social Services and Public Safety, by the end of 2007-08. Further recoveries of £1.9m were secured in 2008-09, bringing the total to around £2.2m in settlements to the health service.

Post payment verification

6.3.1 Given the large volume of claims submitted by FHS practitioners, it is not feasible to conduct prepayment checks on the validity of this expenditure. Consequently, post payment verification (PPV) of expenditure was to be undertaken by the boards on dental, medical, pharmaceutical and ophthalmic claims. The Department has issued guidance to support this.

6.3.2 However, complete PPV checks have not been carried out in respect of general medical services and general pharmaceutical services due to a lack of agreed protocols. Arrangements for

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PPV were established at the time of the new GMS contract, but subsequent guidance from the Department in its Code of Confidentiality and Disclosure of Information in relation to GMS arrangements was not felt to have adequately addressed the issues around patient confidentiality and access to patient records at GP surgeries. Similar issues have affected access to patient medication records within community pharmacies.

6.3.3 A significant amount of work by all parties - DHSSPS, HPSS boards and GPs - has been undertaken to address this. The four boards have agreed a common approach with a view to developing specific interrogation packages using existing software to try to bridge the gap that exists between boards and GPs in respect of access to individual patient records. A limited programme of probity checking has been established in spite of these difficulties, but of necessity it does not focus on all activity at all GP surgeries. Instead, it concentrates on identifying outliers, i.e. GP practices at which there are unexpected or abnormal trends in clinical activities or where specific information obtained warrants further investigation. Using this approach, the boards established a series of non-routine probity visits to GP practices in the latter part of 2006-07.

6.3.4 This was a positive step. Nevertheless, the targeting of outliers through trend analysis should not be seen as an alternative to a full programme of post payment verification, which allows the boards' officers to verify claims against individual patient records. Without a full programme of PPV checks, we have concerns about the adequacy of the assurance on the regularity of GMS and GPS expenditure that is provided to the Departmental Accounting Officer by the boards' Accounting Officers. Further progress is necessary to achieve agreement on an approach that satisfies the requirements of all parties in this matter.

Brangam Bagnall & Co

6.4.1 We published our report in July 2008, examining the events leading to the discovery of fraud perpetrated against the HSC sector by George Brangam, partner in the law firm Brangam Bagnall & Co[20]. An investigation was instigated in July 2006, after irregularities in financial transactions involving the company were reported to the Department by the Causeway Trust. The subsequent investigation uncovered 28 cases where fraudulent payments had been extracted by Brangam from the HSC sector. A total of £277,652 was siphoned out of the health service over a period of 8 years from April 1998 to August 2006. It is possible that the extent of the fraud may have been even greater as some files were destroyed, albeit under routine and legitimate procedures.

6.4.2 A variety of mechanisms were used by Brangam to extract the funds:

- claiming false interim payments on cases;
- overstating final settlements;

20 Brangam Bagnall & Co: Legal Practitioner Fraud Perpetrated against the Health and Personal Social Services, NIAO, NIA 195/07-08, 4 July 2008.

- claiming false settlements;
- settling the same case twice, once fraudulently and once legitimately;
- obtaining refunds from the Social Security Agency Compensation Recovery Unit which were not passed on to the health body to which they were due;
- falsely claiming expenses, for example counsel's fees; and
- claiming expenses from health bodies that had been incurred on other cases to conceal the frauds committed - 'teeming and lading'.

6.4.3 At the heart of these frauds was the failure by the affected HSC organisations to apply correctly the existing controls, and this meant that opportunities were missed to uncover these fraudulent activities. The report highlights the need for health bodies to review their procedures to ensure that they comply with the Department's guidance[21]. In particular, the need for documentary, third party evidence before any financial settlement is made is crucial. The Department is currently finalising the rationalisation of existing clinical negligence guidance. Evidence on the report on Brangam Bagnall & Co was taken from the Department and the Law Society by the Public Accounts Committee on 4 December 2008 and its findings and recommendations were issued on 26 February 2009 (as noted in paragraph 5.45).

National Fraud Initiative

6.5.1 The Audit Commission has run the National Fraud Initiative (NFI) in England and Wales since 1996. The NFI matches electronic data within and between public sector bodies to prevent and detect fraud. So far, around £450m of fraud and overpayments have been identified and the NFI has attracted international recognition.[22]

6.5.2 In 2008-09 the NFI has been extended to Northern Ireland. Using new statutory powers allocated to the Comptroller and Auditor General under the Serious Crime Act 2007, a diverse range of data sources in the public sector has been matched, including housing benefit and tenancy data as well as payroll, occupational pensions, blue badges, rates and private supported care home residents. Central government departments and agencies were required to submit payroll, pensions and trade creditors' data for matching.

6.5.3 HSC bodies' data is included in the matches. The results of the data matching were provided to trusts, boards, agencies and non-departmental public bodies for investigation early in 2009. This is a major step forward in the fight against fraud, but success requires that public bodies ensure effective follow up of the potential fraud that is identified. The HSC should devote adequate resources to following up suspected frauds and overpayments, ensuring that funds are recovered and, where appropriate, the deterrent effects of a prosecution are considered properly. We will be monitoring the outcomes of the NFI 2008 closely.

21 including HSS (F) 67/2006 ' Payments in respect of Litigation and Legal Services in the HPSS – Implementation of controls'
22 National Fraud Initiative 2006-07 (Audit Commission, May 2008)

NIAO Reports 2007 - 2009

Title	HC/NIA No.	Date Published
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