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Northern Ireland Audit Office

General Report on the Health and Social Care Sector by the Comptroller and Auditor General for Northern Ireland – 2012

REPORT BY THE COMPTROLLER AND AUDITOR GENERAL
5 March 2013

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Published 5 March 2013

This report has been prepared under Article 8 of the Audit (Northern Ireland) Order 1987 for presentation to the Northern Ireland Assembly in accordance with Article 11 of that Order.

K J Donnelly
Comptroller and Auditor General

Northern Ireland Audit Office
5 March 2013

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Abbreviations

A&E	Accident and Emergency
AfC	Agenda for Change
ALBs	Arms Length Bodies (in DHSSPS 16 HSC bodies and NIFRS)
BSO	Business Services Organisation
C&AG	Comptroller and Auditor General
CFPS	Counter Fraud and Probity Service
CoPE	Centre of Procurement Expertise
DHSSPS	Department of Health, Social Services and Public Safety: The Department
DFP	Department of Finance & Personnel
FHS	Family Health Service
FPS	Family Practitioner Service
GP	General Practitioner
HEIG	Health Estates Investment Group
HSC	Health and Social Care
HSCB	Health and Social Care Board
ICT	Information & Communication Technology
KSF	Key Skills Framework
NDPB	Non-Departmental Public Body
NHS	National Health Service
NIAO	Northern Ireland Audit Office
NIAS	Northern Ireland Ambulance Service Health and Social Care Trust
NIFRS	Northern Ireland Fire and Rescue Service
PAC	Public Accounts Committee
PaLS	Procurement and Logistics Service
PCC	Patient and Client Council
PEDU	Performance, Efficiency and Delivery Unit
PHA	Public Health Agency
PPE	Post Project Evaluation
RPA	Review of Public Administration
RPCEG	Regional Pharmaceutical Contracting Executive Group
RQIA	Regulation and Quality Improvement Authority
STA	Single Tender Action

Section One:
Introduction

Section One: Introduction

Background

1.1.1 In December 2011, the Comptroller and Auditor General for Northern Ireland (C&AG) published the fourth General Report on the Health and Social Care (HSC) Sector (PC3026 12/11), looking at the results of the audits of both 2009-10 and 2010-11 accounts. The report also examined important issues for the sector such as procurement; operational performance; and health service initiatives and challenges.

1.1.2 This report focuses on:

- the results of the audits of 2011-12 accounts;
- operational performance in the HSC sector;
- procurement issues;
- special measures at the Belfast Health and Social Care Trust;
- implementation of Agenda for Change – a pay modernisation programme; and
- Counter Fraud and Probity Services.

The scope of this report

1.2.1 The report covers the audits of 16 health bodies:

- six health and social care Trusts[1] (the Trusts);
- the Health and Social Care Board (HSC Board);
- three special agencies;
- three special health bodies; and
- three non-departmental public bodies (the NDPBs).

It does not cover findings from the audit of the Department of Health, Social Services and Public Safety (the Department) which are included in my General Report on central government matters[2]. The Northern Ireland Fire and Rescue Service (NIFRS) was the subject of a specific NIAO report in 2011[3] and will be subject to a further report. A full list of the bodies covered by this report and their gross expenditure is shown at Figure 1.

1 Five non regional Trusts and the NI Ambulance Service HSC Trust.

2 Financial Auditing and Reporting: General Report by the Comptroller and Auditor General for Northern Ireland – 2012, (PC3150 10/12: 6th November 2012).

3 NIAO Report: NIFRS: An Organisational Assessment and Review of Departmental Oversight (PC3028 12/11: 20th December 2011).

1.2.2 Since the last NIAO General Report on the Health and Social Care Sector, there has been one NIAO Value for Money report published relating to the sector: The Safety of Services provided by Health and Social Care Trusts[4].

Figure 1: Health and Social Care Bodies covered by this report

	Gross expenditure	
Health Body	**2010-11 £'m Re-stated**	**2011-12 £'m**
Belfast Health & Social Care Trust	1,178	1,218
Northern Health & Social Care Trust	613	627
South Eastern Health & Social Care Trust	517	546
Southern Health & Social Care Trust	522	544
Western Health & Social Care Trust	504	521
NI Ambulance Service Health & Social Care Trust	55	62
Health & Social Care Board	961	969
NI Medical & Dental Training Agency	54	53
NI Blood Transfusion Service	24	24
NI Guardian Ad Litem Agency	4	4
Business Services Organisation	113	122
Public Health Agency	46	51
Patient & Client Council	2	2
Regulation & Quality Improvement Authority	7	7
NI Social Care Council	4	3
NI Practice & Education Council	2	1

Source: HSC 2010-11 and 2011-12 accounts

4 NIAO Report: The Safety of Services Provided by Health and Social Care Trusts (PC3149 11/12: 23rd October 2012).

Section One: Introduction

Key report observations

1.3.1 Key report observations to note are:

Financial Performance and Governance

- All Health and Social Care (HSC) bodies achieved their financial target to "break even" in 2011-12. The HSC sector needs to continue to have a sharp focus on managing available resources effectively so that it can continue to live within its means. (paragraphs 2.2.2 to 2.2.4)

- NIAO welcomes the overall reduction in management costs across the HSC sector. (paragraph 2.2.8)

- In 2010 and 2012 the Department of Finance and Personnel (DFP) drew the attention of public bodies to the need to take all appropriate steps to support the ten day prompt payment commitment. The Department of Health, Social Services and Public Safety does not routinely monitor HSC performance against a ten day target. (paragraph 2.2.13)

- For 2011-12 the financial audit opinions on all HSC bodies were clear, except for the Business Services Organisation where the regularity opinion was qualified. (paragraph 2.4.2)

Operational Performance – Access to Health

- At 31 March 2012, 5,903 outpatients waited for treatment for more than 21 weeks and 775 inpatients waited for treatment for more than 36 weeks. In both cases the target set was that no patients should wait for these periods of time for treatment. We recommend that, for both outpatients and inpatients, Trusts continue to examine ways which will provide an early warning that maximum waiting times may be breached so that corrective action can be taken promptly. (paragraphs 3.2.4 and 3.3.6)

- Over the last two years the HSC sector did not reach the 95 per cent target for patients waiting four hours or less for Accident and Emergency (A&E) treatment. All Trusts experienced a decline in this performance in 2011-12. (paragraphs 3.4.2 and 3.4.3)

- A further target is that no patient should wait longer than 12 hours for A&E treatment. Despite a 1.6 per cent fall in numbers attending A&E in 2011-12 the numbers waiting more than 12 hours for treatment increased by 2,832 to 10,211 (an increase of 38.4 per cent). (paragraph 3.4.6)

- Of the 10,211 patients waiting longer than 12 hours at A&E in 2011-12, 99.5 per cent were in the Belfast, Northern and South Eastern Trusts. (paragraph 3.4.7)

Procurement

- In February 2012 the Department of Health, Social Services and Public Safety (the Department) issued new guidance to its Arms Length Bodies (ALBs) on the use of Single Tender Actions (STAs). The guidance provided clarification on the roles and responsibilities of the Department, ALBs and Centres of Procurement Expertise (CoPEs), and introduced new procedures to tighten the controls surrounding the use of STAs. We welcome actions taken to tighten controls in this area. (paragraphs 4.4.2 and 4.4.3)

- STA (stipulated supplier) expenditure across the HSC sector has fallen from a peak of £9.8 million in 2006-07 to £4.0 million in 2011-12. (paragraph 4.4.4)

Belfast Health and Social Care Trust – Special Measures

- Special measures were introduced for the Belfast Trust in April 2012 to give the Trust the opportunity to ensure an improvement in the quality of service it provides and restore Ministerial confidence in the effectiveness of its operational controls. (paragraphs 5.1.1 and 5.1.2)

- In November 2012 the Minister decided that the special measures arrangements should be relaxed although the Department and the Health and Social Care Board would continue to monitor the Trust's performance closely. We recommend that management in the remaining Trusts also take steps to ensure that the monitoring of the robustness of internal control systems, alongside corporate governance and accountability arrangements, is managed as a key operational priority. (paragraph 5.4.2)

Implementation of Agenda for Change (AfC) – a pay modernisation programme

- We noted in 2010 that:
  - all 2009-10 staff annual performance reviews were to be underpinned by the AfC's 'Knowledge and Skills Framework'; and
  - the Department of Health, Social Services and Public Safety (the Department) planned to undertake a 'benefits realisation review' to measure the effects of AfC. (paragraph 6.1.3)

- The Department informed NIAO that it provided Trusts with £113.6 million for pay modernisation under AfC in 2011-12. (paragraph 6.5.1)

- We consider that an initiative of this importance and cost to the HSC sector must deliver, and demonstrate it has delivered, the intended benefits. It appears that to date, while the substantial costs of AfC have been incurred, few of the benefits of AfC are evident including the formal staff development, and resulting improvements in the delivery of services to patients, which the Knowledge and Skills Framework has yet to secure. (paragraph 6.6.2)

Section One: Introduction

Counter Fraud and Probity Services (CFPS) in the Health and Social Care Sector

- The true extent of fraud against the HSC Sector is unknown. With HSC gross expenditure of £4.4 billon (2011-12), the CFPS 2010-11 Annual Report notes that even a one per cent loss would be over £40 million of the healthcare budget. (paragraph 7.1.2)

- CFPS received 104 fraud referrals (notifications of possible/suspected fraud) in 2011-12. NIAO considers that the build up of a fraud referral and prosecution database will be a valuable resource in understanding the nature and trends in fraud in the HSC sector, in identifying the major areas of risk, and informing proactive measures aimed at tackling it. (paragraph 7.3.4)

- In 2011-12 CFPS recovered £113,000 in respect of payment claims made by Family Health Service practitioners and £30,098 from those who had fraudulently claimed exemption from health service charges. Given the huge size of the healthcare budget and independent estimates that on dental and ophthalmic charges alone fraud/error is estimated to be £2.8 million, we recommend consideration is given to ensuring CFPS have the appropriate level of resources. (paragraph 7.3.3 to 7.3.8)

Section Two:
Financial Performance and Governance

Section Two:
Financial Performance and Governance

2.1.1 The Department of Health, Social Services and Public Safety (the Department) requires that Health and Social Care (HSC) bodies meet a number of financial targets each year and disclose financial performance in their annual reports. Some of these targets are statutory, while others represent best practice. This section of the report provides an overview of HSC bodies' financial performance in 2011-12.

"Break even"

2.2.1 HSC bodies are required to conform to the general requirement of good financial management. Additionally, Trusts are required by statute[5] to ensure that their income is sufficient to meet their expenditure, taking one year with another, to achieve "break even" (Figure 2).

Figure 2: NI Performance – 2011-12 Break even target achieved in all cases with a surplus in 15 of the 16 HSC bodies

Health Body	Resource Revenue Limit	Break even target = + / -0.25% or £20k	Actual Surplus /(Deficit)
	£	£	£
Belfast Health & Social Care Trust	1,126,117,000	2,815,293	173,000
Northern Health & Social Care Trust	580,987,000	1,452,468	96,000
South Eastern Health & Social Care Trust	509,988,000	1,274,970	106,000
Southern Health & Social Care Trust	507,534,000	1,268,835	130,999
Western Health & Social Care Trust	491,606,000	1,229,015	55,000
NI Ambulance Service Health & Social Care Trust	60,659,000	151,648	77,000
Health & Social Care Board	3,945,475,000	9,863,688	108,000
NI Medical & Dental Training Agency	52,891,698	132,229	120,983
NI Blood Transfusion Service	431,001	20,000	9,001
NI Guardian Ad Litem Agency	3,846,317	20,000	1,985
Business Services Organisation	29,963,865	74,910	21,776
Public Health Agency	77,796,000	194,490	191,000
Patient & Client Council	1,915,968	20,000	539
Regulation & Quality Improvement Authority	6,072,364	20,000	(7,011)
NI Social Care Council	2,849,716	20,000	8,652
NI Practice & Education Council	1,240,234	20,000	914

Source: HSC 2011-12 accounts

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

2.2.2 For 2011-12, an organisation was deemed to have met this requirement if it contained its net expenditure within +/- 0.25 per cent or £20,000, whichever was greater. In 2011-12, all HSC bodies achieved their financial target to "break even".

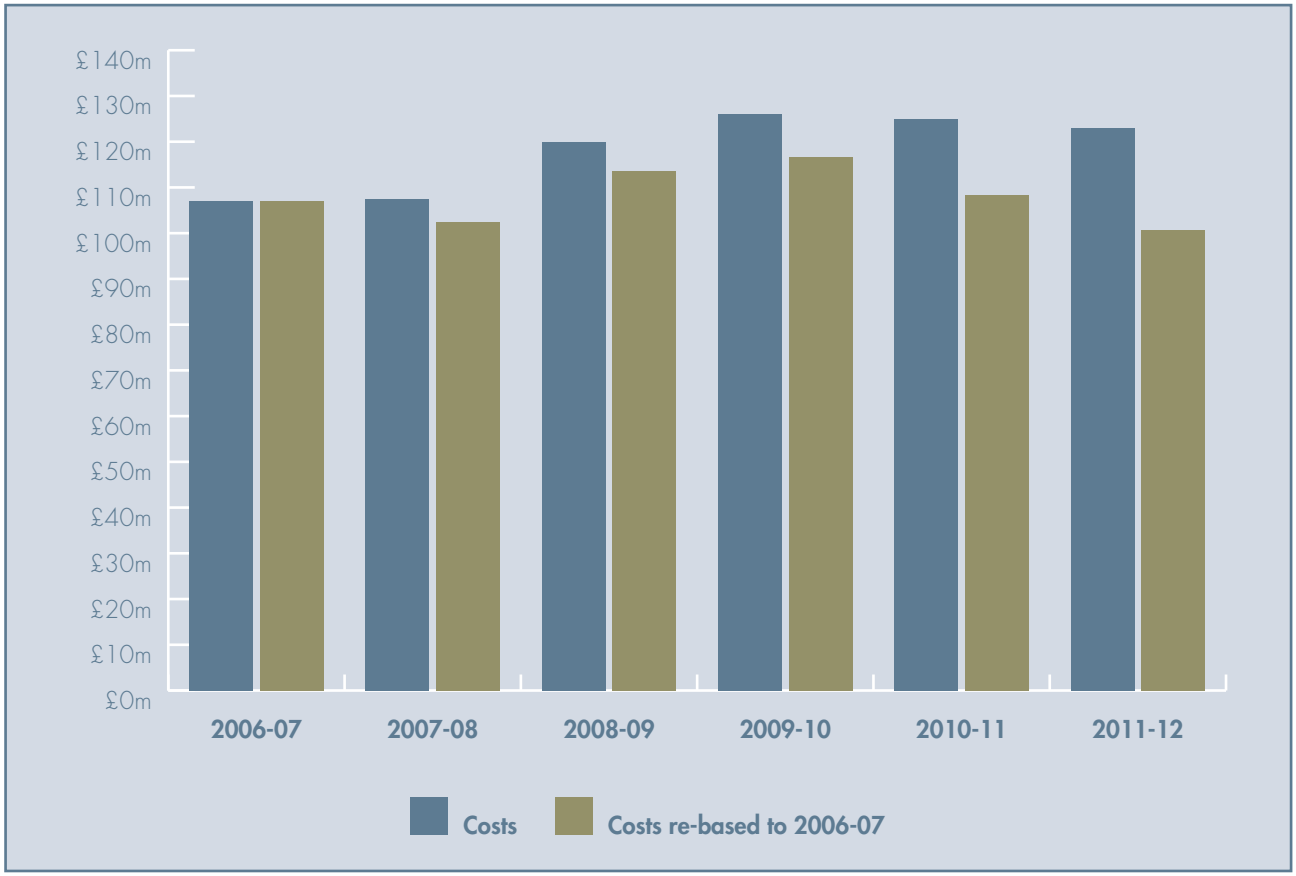
2.2.3 In England 377 (92 per cent) of NHS bodies were in surplus during 2011-12 compared to Northern Ireland where 15 (94 per cent) of HSC bodies were in surplus (Figure 2).

2.2.4 The HSC sector needs to continue to have a sharp focus on managing available resources effectively so that it can continue to live within its means.

Financial Performance Measures

2.2.5 Financial performance measures for the HSC sector include management costs (as a best practice measure of Trusts' efficiency) and performance in paying invoices promptly.

Figure 3: NI Performance - Trust management costs 2006-07 to 2011-12



Source: NIAO using Trust accounts

Section Two:
Financial Performance and Governance

Management costs

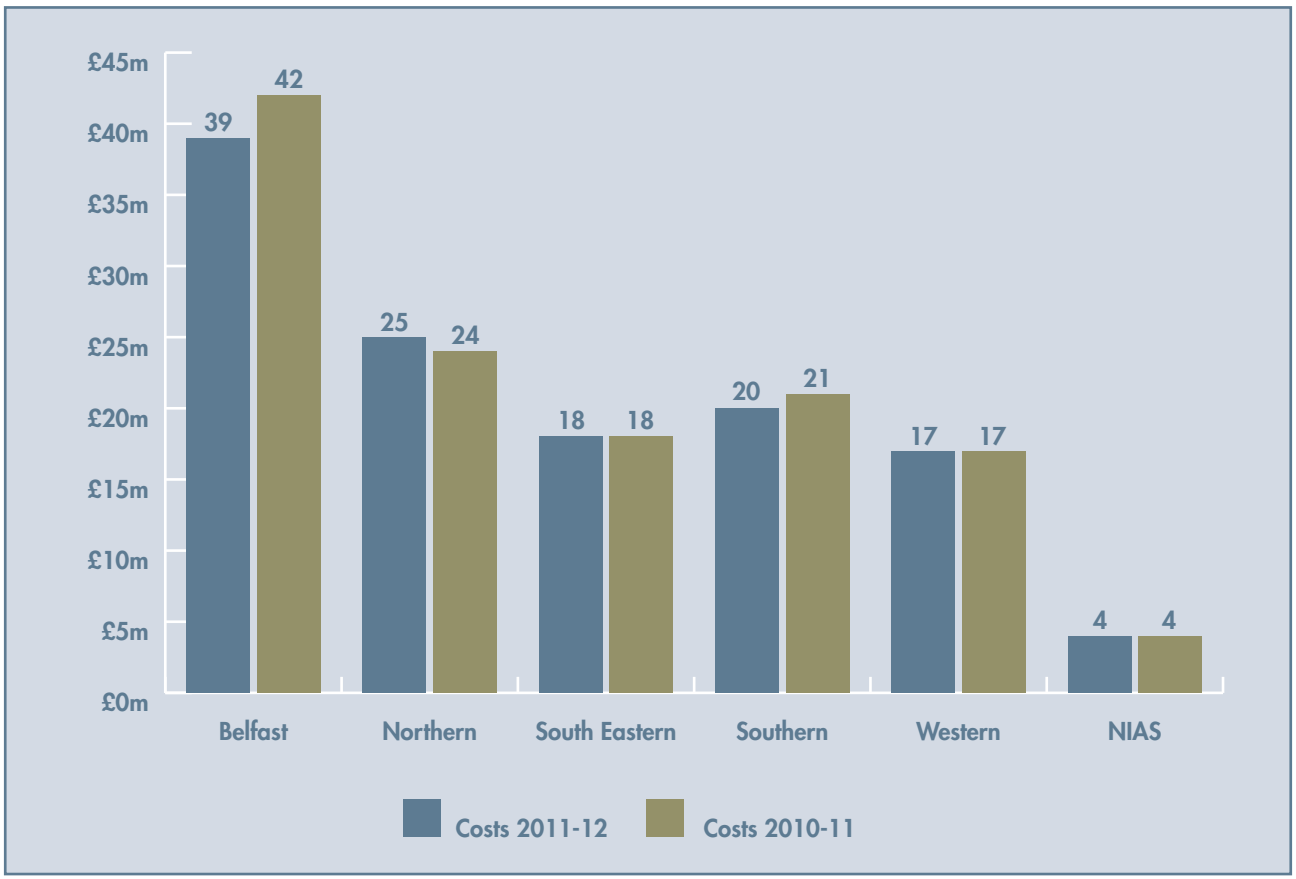
2.2.6 Following the Review of Public Administration (RPA) reforms, which started on 1 April 2007, it was anticipated that management and administration costs across the HSC sector would reduce significantly.

2.2.7 Management costs across the six Trusts have decreased slightly over the last two years to £125 million in 2010-11 and £123 million in 2011-12 since their peak (£126 million) in 2009-10 (Figure 3). However, in 2006-07, the final year before the RPA reforms, management costs incurred by the 18 legacy Trusts and the Northern Ireland Ambulance Service (NIAS) were £107 million; £16 million (15 per cent) less than the 2011-12 costs.

2.2.8 NIAO welcomes the overall reduction in management costs in cash terms between 2009-10 and 2011-12 across the HSC sector.

2.2.9 We note that this comparison across years does not take account of factors such as inflation, pay modernisation progression and changes in employer's superannuation rates which, if factored in, would reduce the variance. The Department has informed us that taking these factors into account to rebase management costs to 2006-07 reduces management costs for 2011-12 to £100.6 million.

Figure 4: Trust Performance - management costs



Source: Trust 2010-11 and 2011-12 accounts

2.2.10 Management costs are broken down by Trust in Figure 4.

Prompt payment

2.2.11 All HSC bodies are required to pay their invoices promptly[6]. Best practice suggests that 95 per cent of payments to creditors should be made within the agreed terms, or 30 days after receipt of a valid invoice where no terms have been agreed. In 2011-12 eight out of the 16 HSC bodies achieved the 95 per cent best practice target (the number of bills paid) with all but one achieving at least 90 per cent compliance. Overall this represents an improvement in performance when compared to 2010-11 (Figure 5).

Figure 5: HSC Bodies performance - prompt payment 2011-12

Health Body	Number of bills paid	Number of bills paid within target	%	Value of bills paid £000s	Value of bills paid within target	%
Belfast Health & Social Care Trust	372,709	341,134	91.5	537,597	481,199	89.5
Northern Health & Social Care Trust	135,096	126,822	93.9	162,952	156,010	95.7
South Eastern Health & Social Care Trust	139,258	128,944	92.6	212,802	204,329	96.0
Southern Health & Social Care Trust	114,327	104,281	91.2	180,118	172,195	95.6
Western Health & Social Care Trust	104,032	100,130	96.2	169,417	164,414	97.0
NI Ambulance Service Health & Social Care Trust	15,081	14,700	97.5	16,640	16,285	97.9
Health & Social Care Board	16,896	15,486	91.7	42,065	37,411	88.9
NI Medical & Dental Training Agency	8,179	7,666	93.7	9,679	9,263	95.7
NI Blood Transfusion Service	3,224	3,102	96.2	18,694	17,947	96.0
NI Guardian Ad Litem Agency	555	548	98.7	574	567	98.8
Business Services Organisation	21,875	20,926	95.7	66,845	65,340	97.7
Public Health Agency	10,851	10,018	92.3	35,654	34,781	97.6
Patient & Client Council	1,110	1,074	96.8	488	451	92.4
Regulation & Quality Improvement Authority	967	930	96.2	964	884	91.7
NI Social Care Council	1,531	1,316	86.0	1,181	1,021	86.5
NI Practice & Education Council	310	306	98.7	379	378	99.7
Total 2012	946,001	877,383	93	1,456,049	1,362,475	94
Total 2011	918,496	847,199	92	422,654	1,329,532	93

Source: HSC 2011-12 accounts[7]

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

7 The NI Social Care Council prompt payment performance declined in 2011-12 as a result of specific issues with two suppliers including one having gone into liquidation (without these issues, the prompt payment performance for 2011-12 would have been above 95 per cent).

Section Two:
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2.2.12 The 2011-12 Financial Auditing and Reporting: General Report by the Comptroller and Auditor General for Northern Ireland considers prompt payment across the public sector. The report highlights that in the HSC sector agreed terms may extend up to 61 days, with some invoices payable by the end of the month following the date of receipt. Invoices paid within this longer timeframe are regarded as having been paid promptly. Although this policy is permitted in Managing Public Money Northern Ireland our view is that the policy goes against the spirit and intention of public sector prompt payment objectives. The HSC Regional Procurement Board, at its June 2012 meeting, agreed that payment terms would move to standard terms of 30 days payment with effect from September 2013.

2.2.13 The Financial Auditing and Reporting: General Report also noted that the Department does not routinely monitor HSC sector performance against a ten day target, as set out in DFP guidance in February 2010 and April 2012 to pay suppliers as promptly as possible and to seek to meet the ten day prompt payment commitment. The report states that four of the Trusts, the South Eastern, Southern, Northern and NIAS paid less than 50 per cent[8] of valid invoices within ten days and performance across all Trusts was only 48 per cent.

2.2.14 We note the anticipated impact the new shared services systems are expected to have on the HSC sector's prompt payment performance from 2013-14. In the interim we would urge the Department and the HSC bodies to explore other ways to pay their suppliers more promptly. Prompt payment targets aim to encourage and promote best practice between organisations and their suppliers and to help the cash flow of business, especially in the current economic climate.

Financial Summary

Revenue

2.3.1 The NI Executive Budget 2011-15 has afforded protection for the health-related element of the DHSSPS budget (approximately 77 per cent of the total DHSSPS current spend) across the four year budget period. The Department will however be required to deliver efficiency savings from its budget, to be achieved through a reconfiguration of the way services are delivered throughout Northern Ireland. The Department told us that a total of £168 million in savings was delivered in 2011-12[9].

2.3.2 In June 2011, the Minister announced a review of health and social care services in Northern Ireland. The report, *'Transforming your care*; the review of Health and Social Care' was published in December 2011 and included a number of recommendations for the future configuration and delivery of services in hospital, primary care and community or other settings. The outcome of this review, and the plans for transformation of services currently under

8 Figures taken from Financial Auditing and Reporting: General Report by the Comptroller and Auditor General for Northern Ireland – 2012, (PC3150 10/12: 6th November 2012).

9 NIAO Report: Review of the Efficiency Delivery Programme (PC3167 12/12: 11th December 2012) examines the efficiency savings of Northern Ireland government departments between 2008 and 2011.

development, will have a significant impact on the revenue and capital plans for the sector. The proposals within the Transforming Your Care review are subject to public consultation which closed on 15 January 2013.

Capital

2.3.3 *"Almost two thirds of the HSC estate needs investment to bring it up to modern day standards; many of our hospitals are 50 to 60 years old, and some mental health facilities are over 100 years old"*[10]. The Northern Ireland Executive's Draft Investment Strategy for Northern Ireland 2011-21 provided an indicative capital allocation to the health sector of £2,321 million over the ten year period. The strategy sets out how this capital provision would be split across the three main areas of primary care, public safety and technology and hospitals' modernisation. The key driver of the investment programme continues to be the need to transform healthcare delivery by providing more treatment and care closer to where people live and work. Other key elements include investment in acute and local hospitals, modernisation and reform of emergency services, and investment in technology.

2.3.4 The Budget[11] 2011-15 allocated the Department £851 million for capital development in health, social services and public safety over the four year budget period. A further £5 million for 2011-12 was allocated to the Department in December 2011 and, following the reallocation of resources to the Department in February 2012, £91.8 million was given to progress three specific projects: Ulster Hospital modernisation; Altnagelvin Tower Block replacement; and Omagh Local Hospital. The current capital budget over the 4 year period 2011-12 to 2014-15 is £963 million.

2.3.5 Capital investment in health and social care infrastructure in 2011-12 amounted to £204 million. Projects completed during 2011-12 include the Antrim Area Hospital Special Palliative Care Unit, the Shankill and Beech Hall Health and Care Centres, the Musgrave Park Hospital Neurology Unit, the Avalon House Respite Unit and the fire lift at the Altnagelvin Tower Block.

2.3.6 In working towards the goals for capital development in the HSC, the Investment Strategy established a number of key projects for the 2011-15 budget period. Progress against a number of significant projects is reported in Figure 6.

10 Strategic Investment Board: Draft Investment Strategy for Northern Ireland 2011-21: Building a Better Future.

11 Northern Ireland Executive's budget 2011-15.

Section Two:
Financial Performance and Governance

Figure 6: Progress of Capital Projects

Project	Current position
Completion of a new mental health facility at Gransha Park.	The new mental health facility at Gransha Park was opened to patients on 7 November 2012.
Redevelopment works at the Ulster Hospital.	The enabling works are now complete and the SEHSCT is in the process of appointing the main contractor.
Opening of the new South West acute hospital (Private Finance Initiative).	The South and West Acute Hospital opened its doors to patients on 21 June 2012, on programme target and within budget.
A new local enhanced hospital in Omagh.	The business case for the first phase of this project, £80 million, was approved in August 2011. It is planned that, following design and procurement, construction of the facility will be completed by 2016.
Redevelopment of the Royal Hospital Site, including a major Critical Care Unit and a new Maternity Unit.	The handover of the Critical Care Unit scheduled for November 2012 has been delayed by several months due to pipe work corrosion. The new date will be determined following investigation and rectification of the problem. The new Maternity Unit is in design and enabling works have commenced on site. As a result of the issue above the completion date (December 2015) will be delayed.
A new Emergency Department and ward block at Antrim Area Hospital.	Value of project is £15.5 million. Currently on site with construction progressing in accordance with agreed programme. Ward due for completion January 2013. Emergency Department due for completion May 2013.
Development of a new satellite Radiotherapy Unit at Altnagelvin Hospital.	Design Team appointed February 2012. Stage 1 design almost complete. DFP approval to the Outline Business Case Stage 2 received on 8 August 2012 and contractual commitments for the Mortuary/Generator were approved 8 October 2012.

Source: DHSSPS

Position on the accounts for 2011-12

2.4.1 The Department sets the timetable for the audit certification of HSC bodies' accounts. In 2011-12 the larger HSC bodies had their accounts certified before the Assembly rose for the summer recess, in line with Departmental timescales. This was a considerable achievement given the constraints of the systems supporting the finance function.

2.4.2 The 2011-12 financial audit opinions on all HSC bodies, except for the Business Services Organisation (BSO), were clear. The regularity part of the audit opinion on the financial statements of BSO was qualified in 2011-12 in respect of expenditure on contracts which was considered to have potentially breached EU procurement rules. Details of the qualification are included within section 4 of this report.

2.4.3 We note that several significant governance issues arose within the Belfast Trust during the year, and as a result the Minister requested that special measures be put in place to monitor the Trust. These issues are set out in section 5 of this report.

Key points and recommendations

2.5.1 Key points to note are:

- All Health and Social Care (HSC) bodies achieved their financial targets to "break even" in 2011-12. The HSC sector needs to continue to have a sharp focus on managing available resources effectively so that it can continue to live within its means. (paragraphs 2.2.2 to 2.2.4)

- NIAO welcomes the overall reduction in management costs in cash terms between 2009-10 and 2011-12 across the HSC sector. (paragraph 2.2.8)

- Meeting prompt payment targets continues to present a considerable challenge to HSC bodies. Eight out of the 16 HSC bodies achieved the 95 per cent best practice target in 2011-12. (paragraph 2.2.11)

- At present HSC bodies can have payment terms which may extend up to 61 days, with some invoices payable by the end of the month following the date of receipt. Invoices paid within this longer timeframe are regarded as having been paid promptly. Our view is that this goes against the spirit and intention of public sector prompt payment objectives. The Department has stated that payment terms will move to standard terms of 30 days with effect from September 2013. (paragraph 2.2.12)

- In 2010 and 2012 DFP drew to the attention of public bodies the need to take all appropriate steps to support the ten day prompt payment commitment. The Department does not routinely monitor HSC performance against a ten day target. (paragraph 2.2.13)

Section Two:
Financial Performance and Governance

- Almost two thirds of the HSC estate needs investment to bring it up to modern day standards. The Northern Ireland Executive's Draft Investment Strategy for Northern Ireland 2011-21 provided an indicative capital allocation to DHSSPS of £2,321 million over the ten year period. Capital investment in health and social care infrastructure in 2011-12 amounted to £204 million. (paragraphs 2.3.3 to 2.3.5)

- For 2011-12 the financial audit opinions on all HSC bodies were clear, except for the Business Services Organisation where the regularity opinion was qualified. (paragraph 2.4.2)

Section Three:
Operational Performance – Access to Health

Section Three:
Operational Performance – Access to Health

3.1.1 This section of the report examines the Health and Social Care (HSC) bodies' operational performance against targets set by the Department of Health, Social Services and Public Safety (the Department). In 2010 the Public Accounts Committee (PAC)[12] warned of the dangers of *"a quick fix approach"* since it *"fails to deliver sustainable solutions to the waiting time problem, largely because it does not address the underlying causes of long waiting times"*.

Hip and Knee appointments

3.1.2 Under the NHS Constitution in England there is a legal right for people to wait no longer than 18 weeks for a hip and knee operation. The Department told us that there is no statutory right in Northern Ireland for specific waiting times for hip and knee operations. The waiting times for hip and knee replacements are included within the general target for elective care and this ensures that across all the elective specialities equal priority is given to all patients. During 2011-12 the waiting time figure was 36 weeks. Within the Belfast Trust, at the end of March 2012, there were 1,562 people waiting for knee and hip replacements of which 55 were waiting longer than 36 weeks. At the end of March 2011 there were 1,210 waiting of which 12 were waiting longer than 36 weeks.

3.1.3 While the availability of resources will impact on patient waiting times, other issues include an ageing population, an increasing number of people who are obese, and a lack of consultant orthopaedic surgeons.

Commissioning Plan Targets

3.1.4 The Commissioning Plan[13], published by the Health and Social Care Board (HSCB) in 2011, sets out specific targets[14] and actions for HSC bodies to be achieved by 31 March 2012, including waiting times for outpatient appointments, inpatient treatment and emergency care targets, (Figure 7). The Commissioning Plan has no targets for hip and knee replacements in Northern Ireland although they are included within the overarching elective care waiting time targets.

3.1.5 Targets can be an important tool in monitoring performance across the HSC sector. Care however needs to be exercised to ensure that targets are directed at key performance measures and that, in striving to reach a target in one area of activity, there is no detrimental impact on the overall care received by patients. For the areas noted in Figure 7 the following paragraphs examine in some detail the operational performance reported by the Department.

12 PAC Report on the Performance of the Health Service in Northern Ireland, (35/09/10R: 21 January 2010).

13 The Commissioning Plan 2011/2012 published by the Health and Social Care Board, 15th November 2011.

14 The Department publishes quarterly reports on performance against the Commissioning Plan targets in the "Northern Ireland Waiting Time Statistics" bulletins.

Figure 7: Selected HSCB Commissioning Plan targets for HSC Bodies 2011-12

	Target
Outpatient	At least 50 per cent of patients wait no longer than nine weeks for a first outpatient appointment. All patients are seen for a first outpatient appointment within 21 weeks.
Inpatient	At least 50 per cent of inpatients and day cases are treated within 13 weeks. No patient waits longer than 36 weeks for treatment.
Emergency	95 per cent of patients attending A&E Departments are either treated and discharged home, or admitted within four hours of their arrival in the department. No patient attending any A&E Department should wait longer than 12 hours either to be treated and discharged home or admitted.

Source: The Commissioning Plan Direction (Northern Ireland) 2011

Outpatients

3.2.1 The total number of completed outpatients waits in 2011-12 was 503,965 compared to 492,173 in 2010-11. These figures represent the total number of attendances at a first outpatient appointment, including the independent sector. The 11,792 increase from 2010-11 represents a rise in demand of two per cent.

3.2.2 At 31 March 2012 16,542 more patients (19.1 per cent) were waiting for outpatient appointments than two years earlier when the figure was 86,501. However, the number of people waiting at the end of March 2012 for an appointment was 103,043, down 3,163 from 106,206 at March 2011, despite the 2011-12 increase in patient numbers. Of those people waiting at the end of March 2012, 28,278 (27.4 per cent) had waited longer than nine weeks for a first outpatient appointment (Figure 8) with all Trusts comfortably achieving the 50 per cent target set by the Department for this period of waiting.

3.2.3 The Department has informed us that following the introduction of targets from April 2011 onwards, changes in the methodology used to compile official waiting time data enabled the 21 week target to be monitored. However, it is not possible to produce comparable data for waiting times prior to that date.

3.2.4 During 2011-12, Trusts had a target that no one should wait longer than 21 weeks for an outpatient appointment (Figure 7) but at March 2012 there were 5,903 patients waiting longer than 21 weeks for an outpatient appointment.

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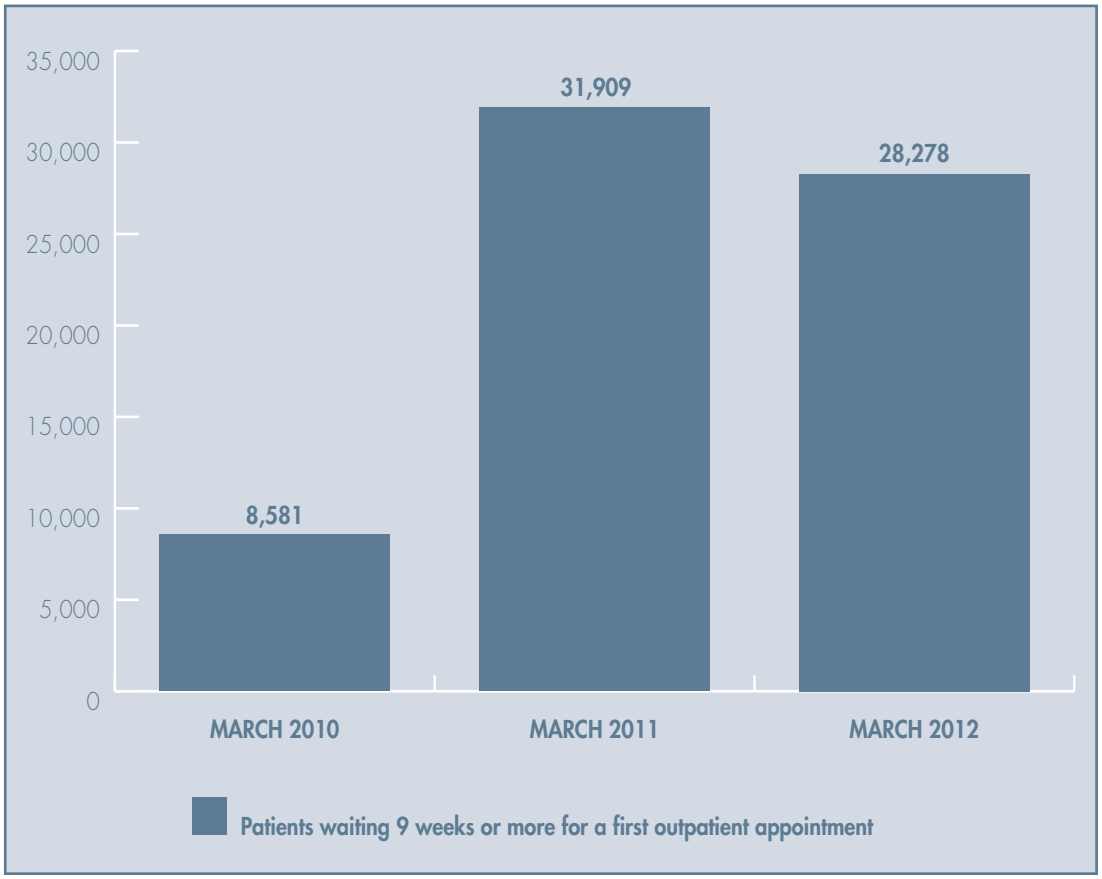
Figure 8: NI Performance – Outpatient Waiting Times Beyond Target



Source: DHSSPS NI Waiting Times Statistics

Inpatients

3.3.1 During 2011-12, the number of patients having completed their inpatient treatment increased by 20,158 from 178,697 in 2010-11, to 198,855 in 2011-12 (an increase of 11 per cent). Figure 9 provides a breakdown of patient numbers by Trust.

3.3.2 All non regional Trusts achieved the 50 per cent target set by the Department for inpatients to receive treatment within 13 weeks (Figure 7). At the 2011-12 peak in September 2011 a total of 26,611 patients were waiting longer than 13 weeks for inpatient treatment (Figure 10).

3.3.3 Figures 9 and 10 show that as the number of inpatient treatments increase towards the end of 2011-12 the number of patients waiting for treatment falls (a similar pattern occurs in respect of outpatients). The Department told us that:

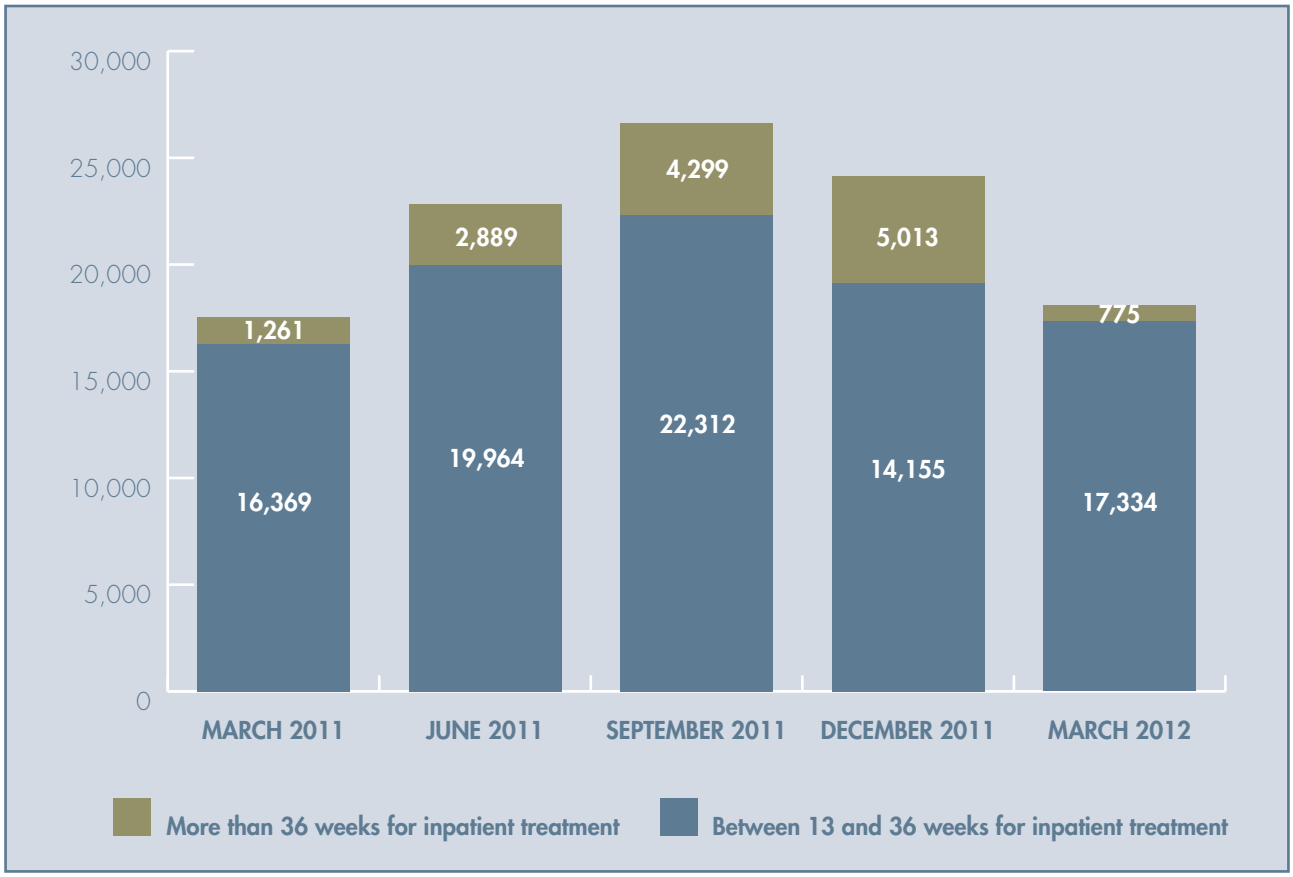
- in relation to the number of patients treated in quarter four, traditionally, a higher proportion of activity is undertaken during the second half of the year as Trusts work towards

Figure 9: Trust Performance - Completed Inpatient Treatment Numbers

	Jun-11	Sep-11	Dec-11	Mar-12	Total
Belfast	19,045	17,263	19,362	19,649	75,319
Northern	6,351	6,194	7,291	7,141	26,977
South Eastern	6,665	6,540	7,031	8,430	28,666
Southern	7,571	7,640	8,690	10,600	34,501
Western	7,755	7,376	8,768	9,493	33,392
Total	47,387	45,013	51,142	55,313	198,855

Source: DHSSPS NI Waiting Times Statistics

Figure 10: NI Performance - Inpatient Waiting Times Beyond Target



Source: DHSSPS NI Waiting Times Statistics

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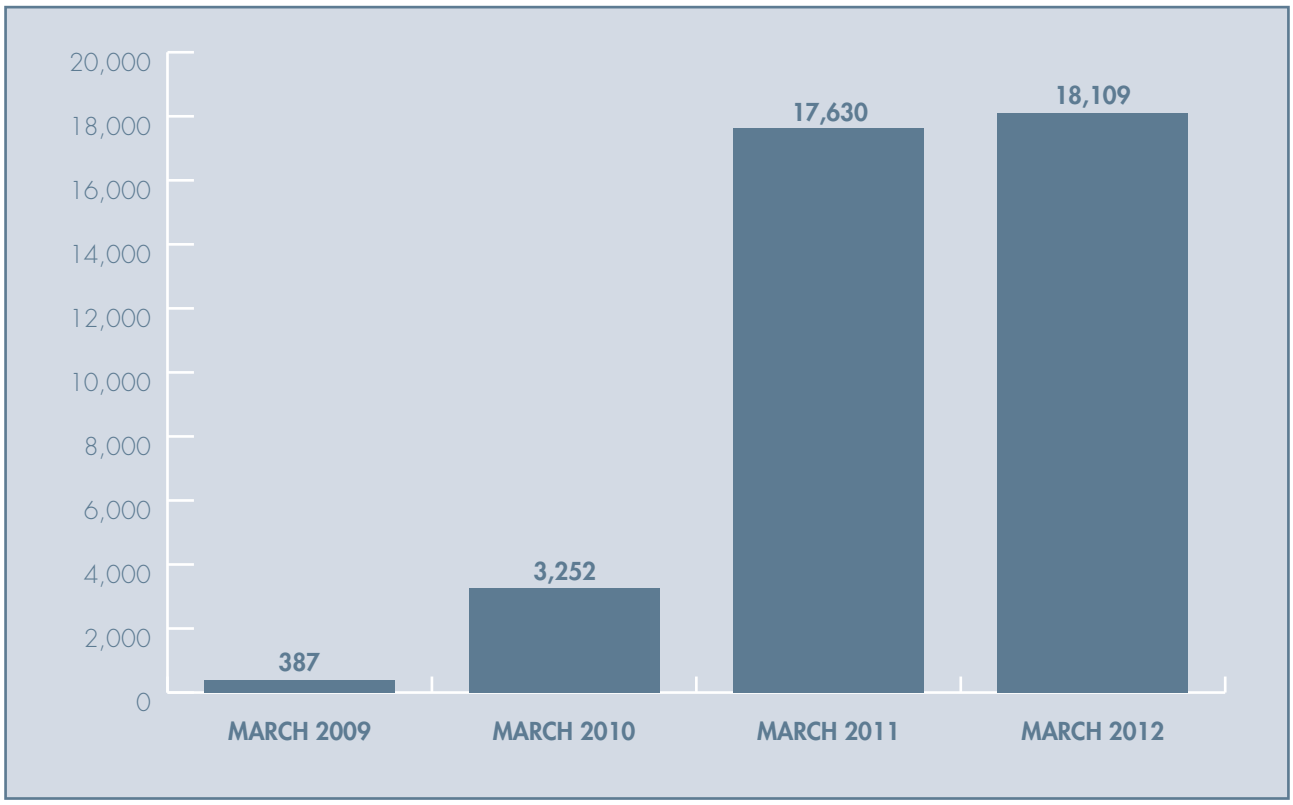
Figure 11: NI Performance - Patients waiting longer than 13 weeks for inpatient treatment



Source: DHSSPS NI Waiting Times Statistics

achievement of Ministerial maximum waiting time targets/standards. In order to do this, Trusts produce plans to undertake additional activity which is funded using in year non-recurrent funding which is normally not confirmed until mid-year. Consequently, total activity increases in the latter half of the year.

- core activity levels are traditionally lower in quarters one and two due to the higher number of bank and public holidays during that time and the fact that this is the main holiday/ annual leave season.

3.3.4 The Department added that the HSCB closely monitors the delivery of agreed core activity levels by Trusts throughout the year and recognises that, for the above reasons, annual activity is not delivered on an equal basis across the year.

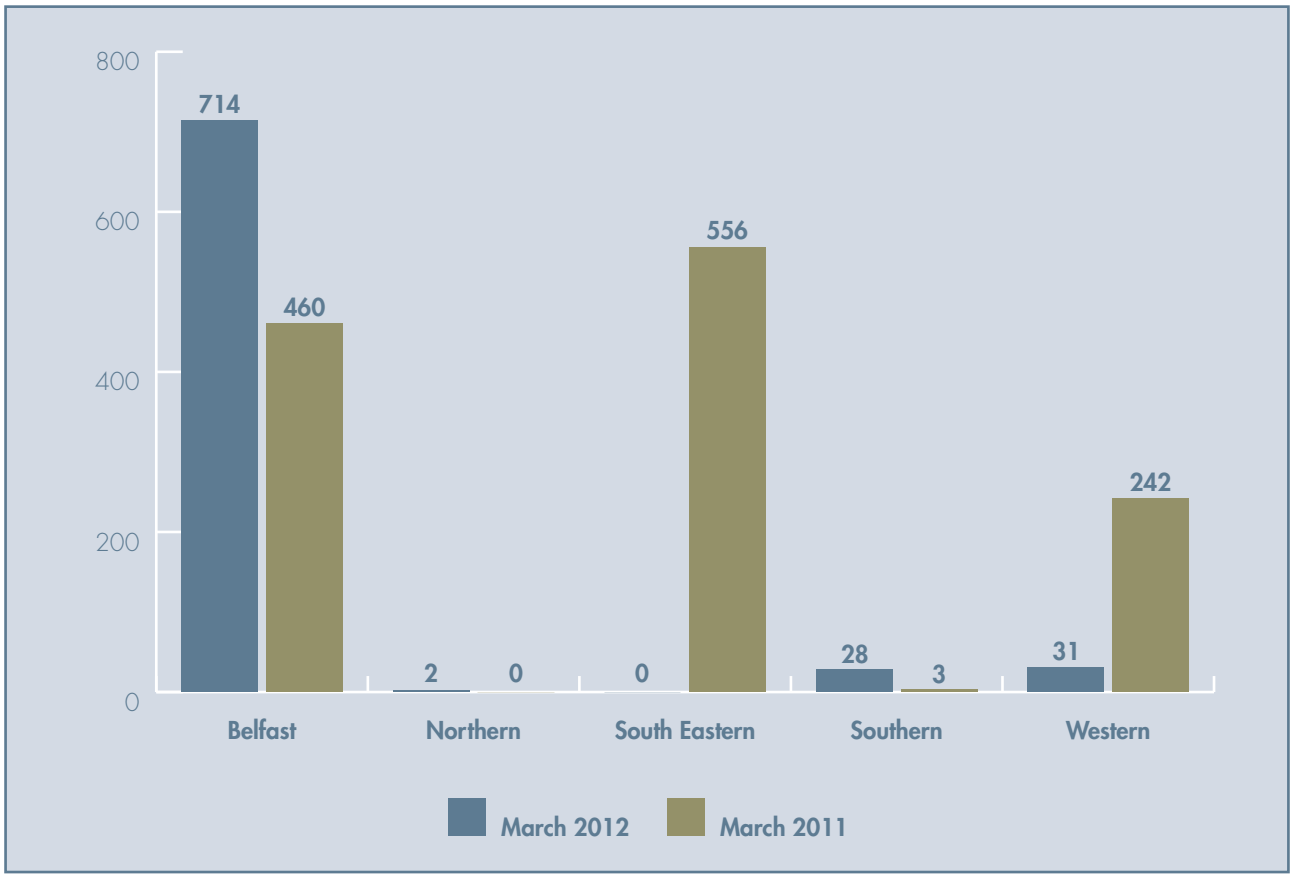
3.3.5 Although at the end of March 2012, there were 18,109 (35.7 per cent) patients waiting more than 13 weeks for inpatient treatment compared to 17,630 in March 2011, the rate of increase (three per cent) is well below the 11 per cent increase in demand for inpatient treatment. The number of

inpatients waiting longer than 13 weeks for treatment may have increased in 2011-12 but at a reduced rate when compared to recent years (Figure 11).

3.3.6 During 2011-12, Trusts had a target that no patient should wait longer than 36 weeks for inpatient treatment (Figure 7). At the end of March 2012 there were 775 patients waiting more than this period for treatment, an improvement on the 1,261 patients waiting in March 2011. This reduction was achieved in a year when the demand for inpatient treatments increased by 11 per cent (paragraph 3.3.5).

3.3.7 Of the 775 patients waiting longer than 36 weeks for inpatient treatment (Figure 10), 714 were waiting for treatment with the Belfast Trust, an increase of 254 patients from March 2011 (Figure 12). At 31 March 2012 there were no inpatients waiting 36 weeks for treatment in the South Eastern Trust (a reduction of 556 from March 2011).

Figure 12: Trust Performance - Patients waiting longer than 36 weeks for inpatient treatment



Source: DHSSPS NI Waiting Times Statistics

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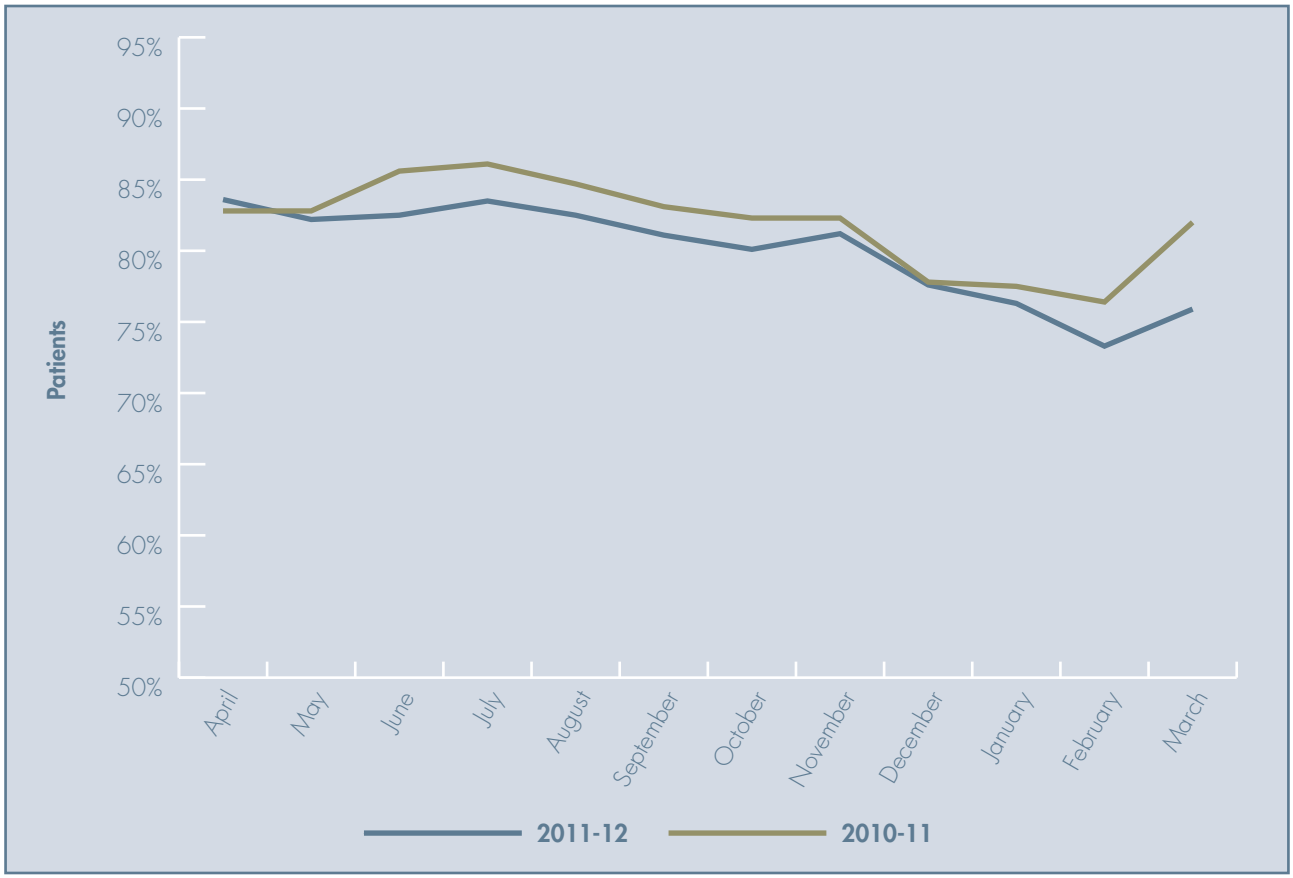
Emergency care targets

3.4.1 Since the introduction of the emergency care waiting times target in April 2007, the total number of new and unplanned attendances at Accident & Emergency (A&E) has increased from 642,636 in 2007-08 to 699,881 in 2010-11. 2011-12 however has seen a decrease in new and unplanned attendances of 11,185 to 688,696 (1.6 per cent) when compared with 2010-11.

3.4.2 The HSCB 2011-12 Commissioning Plan includes a target that no patient attending A&E should have to wait more than 12 hours and that 95 per cent of patients should be treated within four hours. Figure 13 shows that over the last two years the Northern Ireland Health and Social Care sector has failed to reach the 95 per cent target for patients waiting four hours.

Figure 13: NI Performance - Percentage of patients treated and discharged or admitted within four hours of attending A&E Departments



Source: NIAO using DHSSPS NI Waiting Times Statistics

3.4.3 Performance in achieving the emergency care target of treatment within four hours is in part seasonal, peaking in the months of March to July and dipping in the period from November to February (see Figure 13). All Trusts experienced a decline in 2011-12 in their annual performance against the four hour emergency care target, ranging from the Western Trust where there was a marginal decrease of 0.4 per cent between 2010-11 and 2011-12, and the Southern Trust which fell by 4.2 per cent.

3.4.4 The Department told us that waiting time in A&E is influenced by a number of factors which if not working effectively lead to a reduction in the number of inpatient beds within hospitals. These include:

- internal hospital processes such as effective multidisciplinary working;
- timely access to diagnostics to prevent admission and facilitate discharge;
- outcome focused patient planning and effective discharge planning including timely transport;
- developments of alternatives to hospital care and appropriate use of primary care services;
- timely discharge arrangements; and
- collaboration with primary care professionals.

3.4.5 Recognising the increase in waiting times in A&E the Minister announced the establishment of the Improvement Action Group in March 2012, to eliminate 12 hour waits and significantly reduce four hour waits. In his announcement the Minister recognised that an Emergency Department does not stand alone from the rest of a hospital and indeed, is dependent for its efficient functioning, on performance across the hospital. He added that improvement will require concerted attention across all parts of the service, because all aspects of health and social care have essential contributions to make to ensuring appropriate flow of patients through the system. The work of the Improvement Action Group continues.

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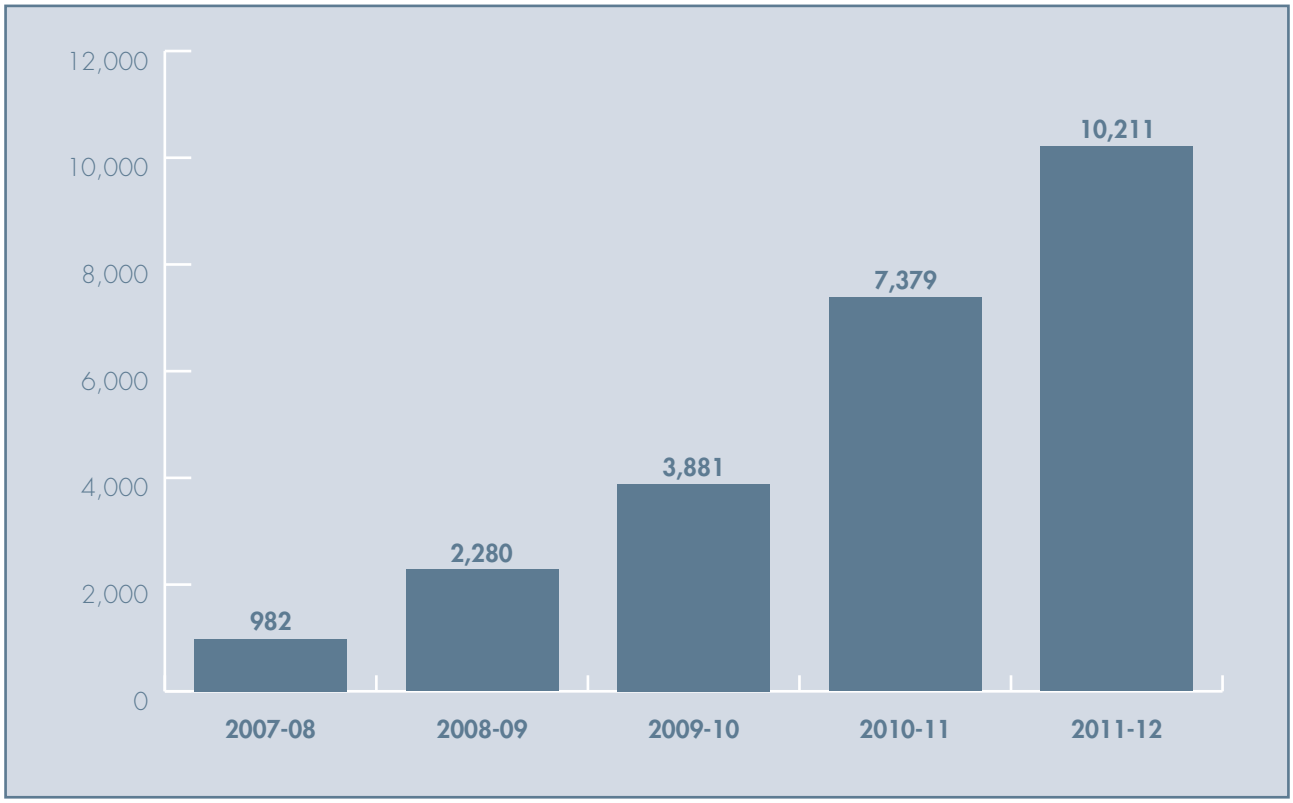
Figure 14: NI Performance - Total number of patients waiting longer than 12 hours in A&E Departments



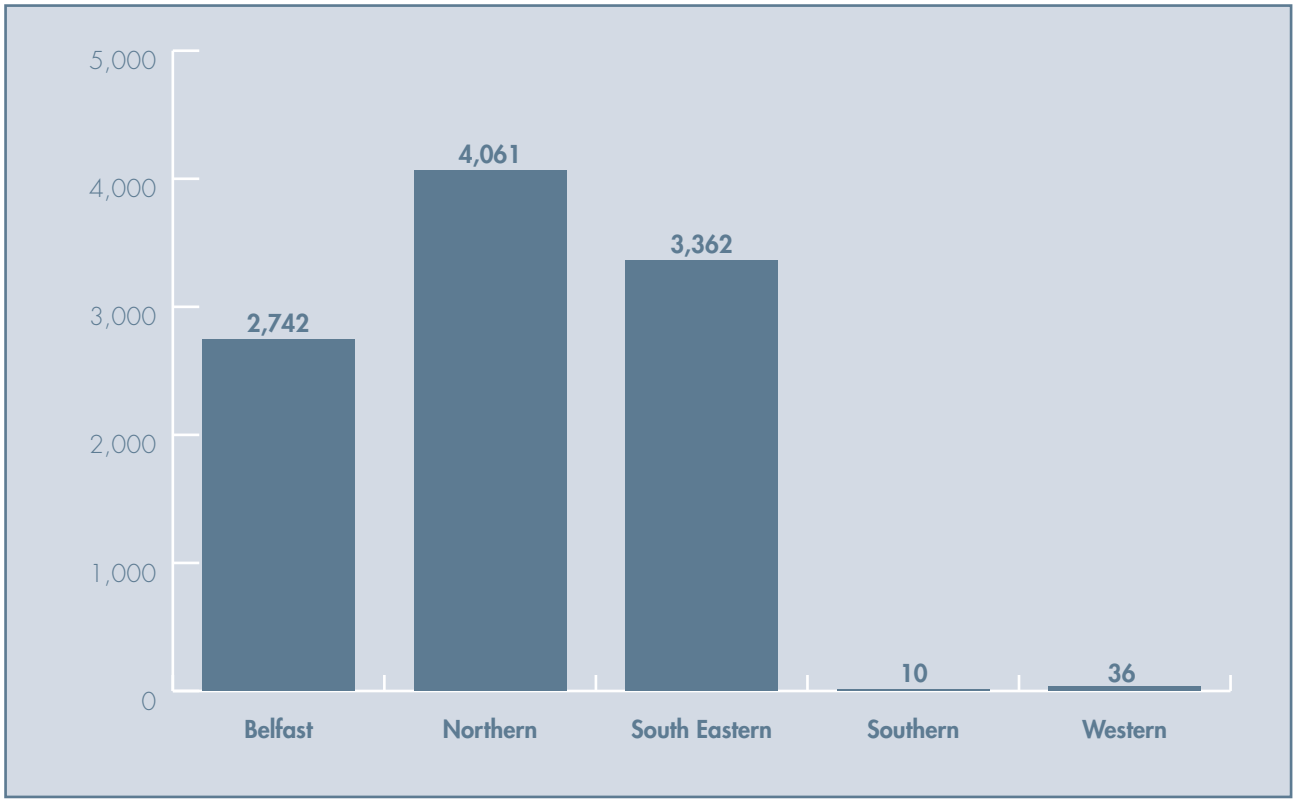
Source: DHSSPS NI Waiting Times Statistics

3.4.6 The numbers of patients waiting over 12 hours for treatment at A&E has risen from 982 in 2007-08 to 7,379 in 2010-11 and 10,211 in 2011-12 (Figure 14). The target is that no patient should wait longer than 12 hours for treatment. Despite a 1.6 per cent fall in the number of patients attending A&E in 2011-12 the number waiting more than 12 hours for treatment increased by 2,832 (38.4 per cent). An important factor is the number of patients attending emergency departments who subsequently require admission as patient acuity[15] has increased.

3.4.7 Of the 10,211 patients waiting longer than 12 hours at A&E in 2011-12, 99.5 per cent were in the Belfast, Northern and South Eastern Trusts (Figure 15).

15 Acuity refers to the level of severity of a patient's condition.

Figure 15: Trust Performance - Total number of patients waiting longer than 12 hours in A&E Departments during 2011-12



Source: DHSSPS NI Waiting Times Statistics

3.4.8 The Department told us that there is no single reason that explains the difference between Trusts in the number of patients waiting longer than 12 hours. The factors influencing performance are multi-faceted. The effective flow of patients through acute hospital care settings is dependent on a wide range of activities both to prevent hospital admission and support prompt and safe discharge, as described in paragraph 3.4.4 above. The HSCB in partnership with Trusts is exploring the causes of delays in the patient journey across the whole system of care. In the Department's view strong performance against the 12 hour target requires:

- a culture which values strong clinical and managerial leadership and empowerment;
- patients in the emergency department to be viewed as part of an integrated system;

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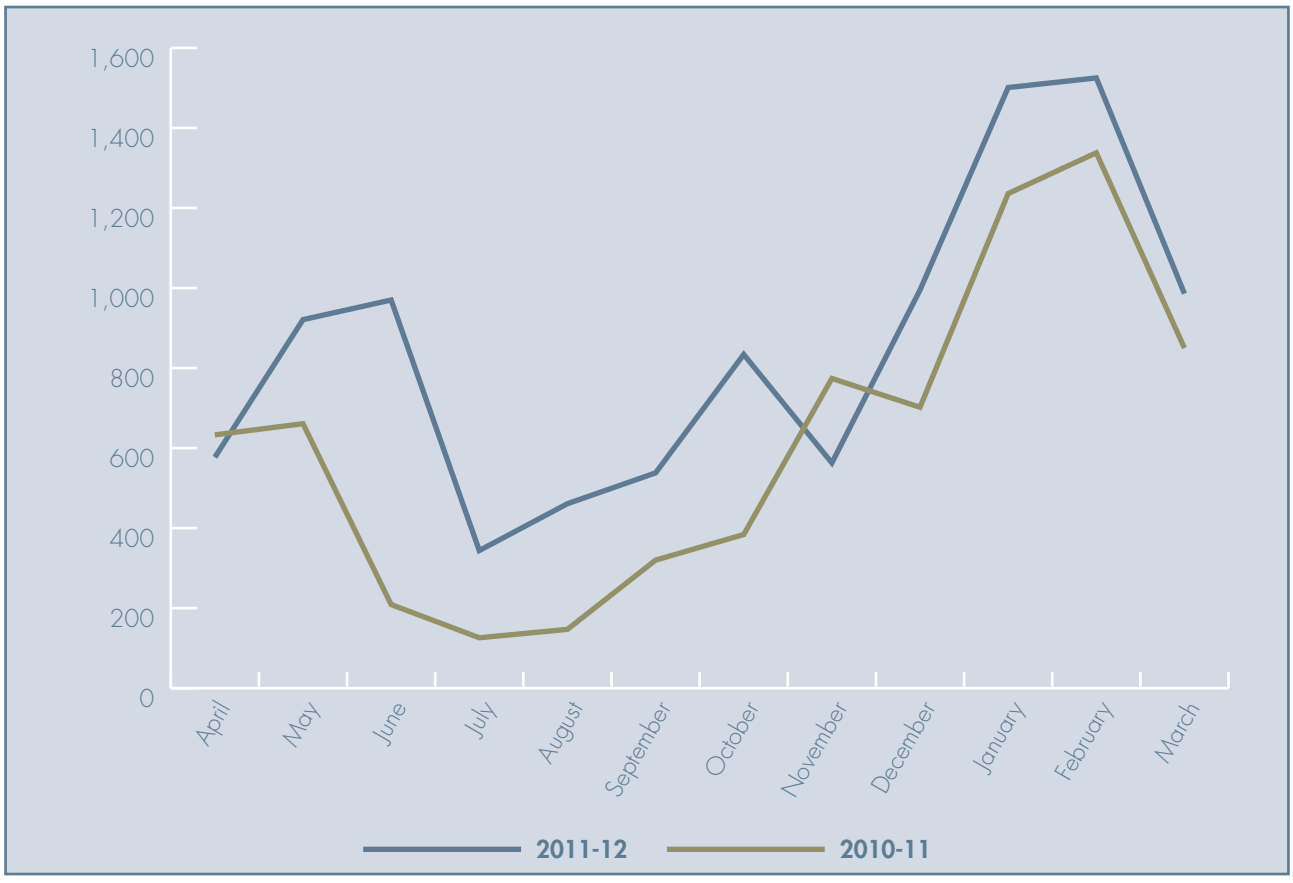
- attention to be paid to other indicators such as length of stay, occupancy and the experience of patients;
- significant cooperation and integration between hospital and community staff; and
- effective diversion schemes and good cooperative partnerships with primary care staff.

3.4.9 There is evidence that, as was the case with performance against the four hour A&E waiting target, performance against the 12 hour waiting target is in part seasonally affected (Figure 16).

3.4.10 The Department informed us that following the Minister's commitment in March 2012 that action should be taken to eliminate 12 hour waits at A&E Departments, Trusts' performance against the 12 hour target has improved.

Figure 16: NI Performance - Patients waiting longer than 12 hours in A&E Departments



Source: DHSSPS NI Waiting Times Statistics

A comparison of the period April – October 2011 to April – October 2012 shows that there has been a 64 per cent reduction in the number of patients waiting longer than 12 hours in the Belfast Trust, a 43 per cent reduction in the South Eastern Trust and a 50 per cent reduction in the Northern Trust.

Key points and recommendations

3.5.1 Key points to note are:

- Targets can be an important tool in monitoring performance in the Health and Social Care (HSC) sector. Care however needs to be exercised to ensure that targets are directed at key performance measures and that, in striving to reach a target, there is no detrimental impact on the overall care received by patients. (paragraph 3.1.5)

- At 31 March 2012, 5,903 outpatients waited for treatment for more than 21 weeks and 775 patients waited for inpatient treatment for more than 36 weeks. In both cases the target set was that no patients should wait for these periods of time for treatment. We recommend that for both outpatients and inpatients Trusts continue to examine ways which will provide an early warning that maximum waiting times may be breached so that corrective action can be taken promptly. (paragraphs 3.2.4 and 3.3.6)

- Over the last two years the HSC sector did not reach the 95 per cent target for patients waiting four hours or less for Accident & Emergency (A&E) treatment. All Trusts experienced a decline in this performance in 2011-12. (paragraphs 3.4.2 and 3.4.3)

- A further target is that no patient should wait longer than 12 hours for A&E treatment. Despite a 1.6 per cent fall in numbers attending A&E in 2011-12 the numbers waiting more than 12 hours for treatment increased by 2,832 to 10,211 (an increase of 38.4 per cent). (paragraph 3.4.6)

- Of the 10,211 patients waiting longer than 12 hours at A&E in 2011-12, 99.5 per cent were in the Belfast, Northern and South Eastern Trusts. (paragraph 3.4.7).

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Procurement

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Background

4.1.1 In 2010-11, Health and Social Care (HSC) bodies incurred £750 million (28 per cent)[16] of the total procurement expenditure across central government departments and their arm's length bodies. This expenditure increased to £773 million in 2011-12.

4.1.2 HSC bodies are subject to the Department of Finance and Personnel's (DFP) Northern Ireland Public Procurement Policy, published in November 2010. Within that framework, Procurement Guidance Notes (PGNs) are issued by DFP's Central Procurement Directorate (CPD) in consultation with Centres of Procurement Expertise (CoPEs), and subject to the approval of the NI Procurement Board, on which Department of Health, Social Services and Public Safety (the Department) is represented.

4.1.3 Two CoPEs provide services specifically to the HSC sector; the Department's Health Estates Investment Group (HEIG)[17] for construction and design services, and the Business Services Organisation's (BSO) Procurement and Logistics Service (PaLS)[18] for goods and services. The total expenditure processed through BSO PaLS was in the region of £460 million and £486 million in 2010-11 and 2011-12 respectively.

4.1.4 This section of the report follows up on significant procurement matters identified within the 'General Report on the Health and Social Care Sector - 2010 and 2011'; considers the outcome of the Department's review of procurement across health sector bodies; and provides comment on other procurement issues identified during the 2011-12 audits of HSC bodies.

Significant procurement issues identified in our 2010 and 2011 report

4.2.1 During 2010-11 Internal Audit in the non regional Trusts limited the assurance[19] provided to the respective Accounting Officers on procurement and contract management issues[20]. The C&AG reported the Internal Audit findings in the 2010-11 financial statements of each Trust.

4.2.2 Internal Audit carried out follow-up reviews in this area in 2011-12 and provided satisfactory assurance across all of the non regional Trusts. In general, Internal Audit found that adequate progress had been made in addressing the weaknesses identified in the prior year, and that controls surrounding procurement and contract management in operation during 2011-12 were sufficiently robust.

16 Central Procurement Directorate: Procurement Activity Report 2010-11

17 HEIG manages major capital works on behalf of HSC bodies

18 Formerly the Regional Supplies Service in the Central Services Agency and provides contracting, procurement and logistics services to HSC bodies.

19 A Limited Internal Audit Assurance opinion means there is considerable risk that the system will fail to meet its objectives. Prompt action is required to improve the adequacy and effectiveness of risk management, control and governance.

20 The non-capital element of HSC procurement is mainly completed through BSO PaLS.

Departmental review of procurement across Health Sector Bodies

4.3.1 In June 2011, the Minister announced a review of procurement expenditure controls between and within the Department and its 17 Arm's Length Bodies (ALBs – including 16 health and social care bodies[21]). The overall objective of the review was to *'examine the procedures and practice of the Department and its ALBs as regards compliance with the requirements of public procurement policy, to determine the effectiveness of these arrangements and to make recommendations for improvement where required.'*

4.3.2 As part of the Department's review, the Permanent Secretary wrote to the Accounting Officers in the health sector requesting assurance that appropriate arrangements were in place and were being applied in line with guidance.

4.3.3 The Department found that while explicit assurance was generally forthcoming on the due operation of procedures and control systems, the HSC bodies were less willing to rule out the potential existence of individual cases of non-compliance, particularly in respect of estate related services and predominantly service and maintenance contracts. The report noted that, given the number of contracts concerned, the need to allow for their various expiry dates and the resources available to support improvement, it is expected to take three to five years before comprehensive compliance in this area can be ensured. The Department has advised that a programme of work will be designed and taken forward by reference to the degree of risk attached to the contracts.

4.3.4 Findings of the review also indicated that heavy reliance is placed by bodies on the professional advice and guidance provided by the CoPEs and that there is a clear drive by HSC bodies to increase the level of CoPE coverage of their goods and services expenditure. The Department has advised that HEIG and PaLS are to strengthen their capacity to support compliant and value for money procurement in ALBs.

4.3.5 The report concluded that, in respect of HSC procurement, there remains room for improvement and made 26 recommendations to that effect. The Department noted that, in part, the necessary improvement should result from a restating of, and adherence to, such basic requirements as the checking of contract fulfilment prior to payment authorisation, and a proactive review process for existing contracts to establish at an earlier stage the need for retendering or renewal. ALBs should ensure that they make optimum use of CoPE guidance and assistance.

21 Arms Length Bodies (ALBs) for DHSSPS means the 16 HSC bodies and NIFRS. This report does not include NIFRS (paragraph 1.2.1).

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4.3.6 The Department has set a timetable for the implementation of these recommendations and overall progress will be reported to the HSC Regional Procurement Board on which the Department is represented.

Use of Single Tender Actions

4.4.1 Established public procurement guidance allows departments and their ALBs to set aside competition requirements and adopt a single tender action (STA) where a sound case, based on the need to continue a public service and/or safeguard the public interest, can be made for taking this approach. In the HSC, such considerations may centre on patient safety, and may manifest itself in the purchasing of a particular brand or model of equipment to ensure compatibility with existing equipment or to standardise clinical devices, for example, infusion pumps used by a variety of staff to administer fluids to patients.

4.4.2 In February 2012, following the review of procurement, the Department issued new guidance to ALBs on the use of STAs[22]. The purpose was to provide Accounting Officers in ALBs with a comprehensive framework for their organisations' STA approvals that will:

- ensure compliance with procurement law, policy and good practice;
- minimise their administration; and
- ensure full transparency in all types of STA i.e. sole source suppliers and contract extensions, as well as stipulated suppliers[23] (prior to February 2012 the Department's monitoring of STAs only extended to stipulated suppliers).

4.4.3 The guidance provided clarification on the roles and responsibilities of the Department, ALBs and CoPEs, and introduced new procedures to tighten the controls surrounding the use of STAs. In addition, the guidance provided a new STA approval request form.

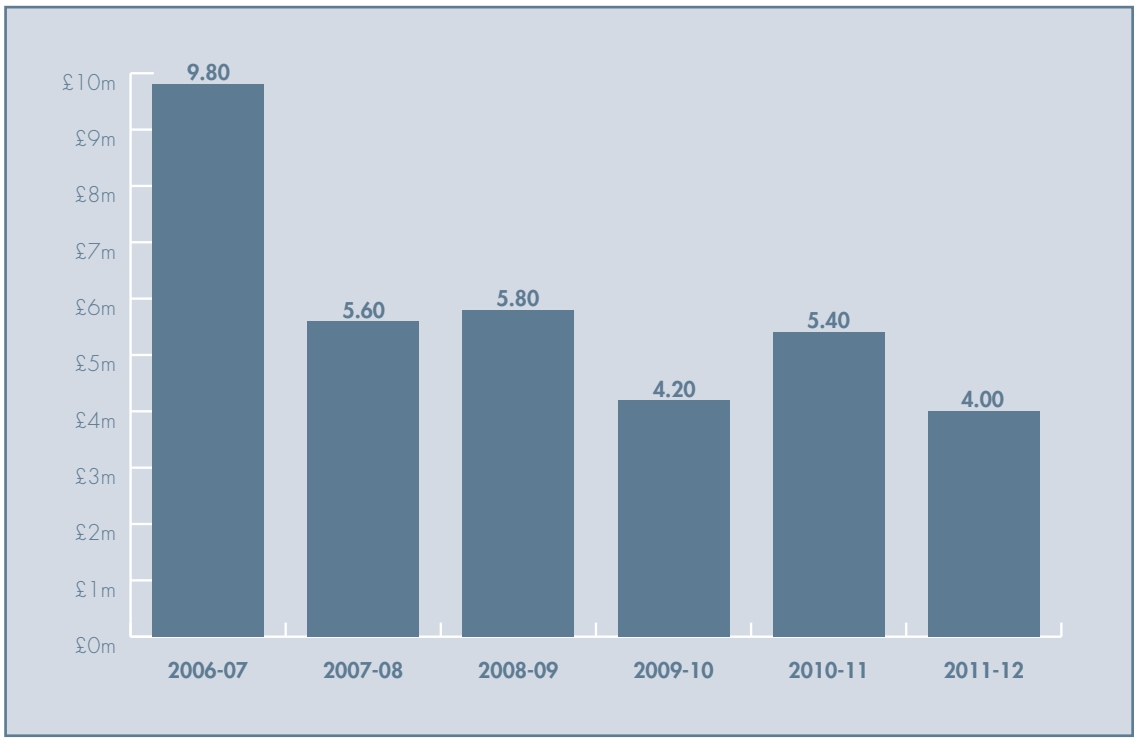
4.4.4 For value for money reasons, the use of STAs should be limited to cases where it is absolutely necessary. In 2006-07, STA (stipulated supplier) expenditure was at a peak of £9.8 million falling to £4.0 million in 2011-12 (Figure 17). Sole source supplier and contract extension STA expenditure in February and March 2012 was £1.8 million and is likely to include agreements predating February 2012 being reported for the first time. We will review the extent of all categories of STA in 2012-13.

4.4.5 The largest users of STAs in the HSC are the five non-regional Trusts. As Figure 18 below shows there is a mixed picture year on year.

22 Circular HSC(F) 05/2012: Guidance on Approval Requests for Single Tender Action for Goods and Services Procurement by DHSSPS Arm's Length Bodies.

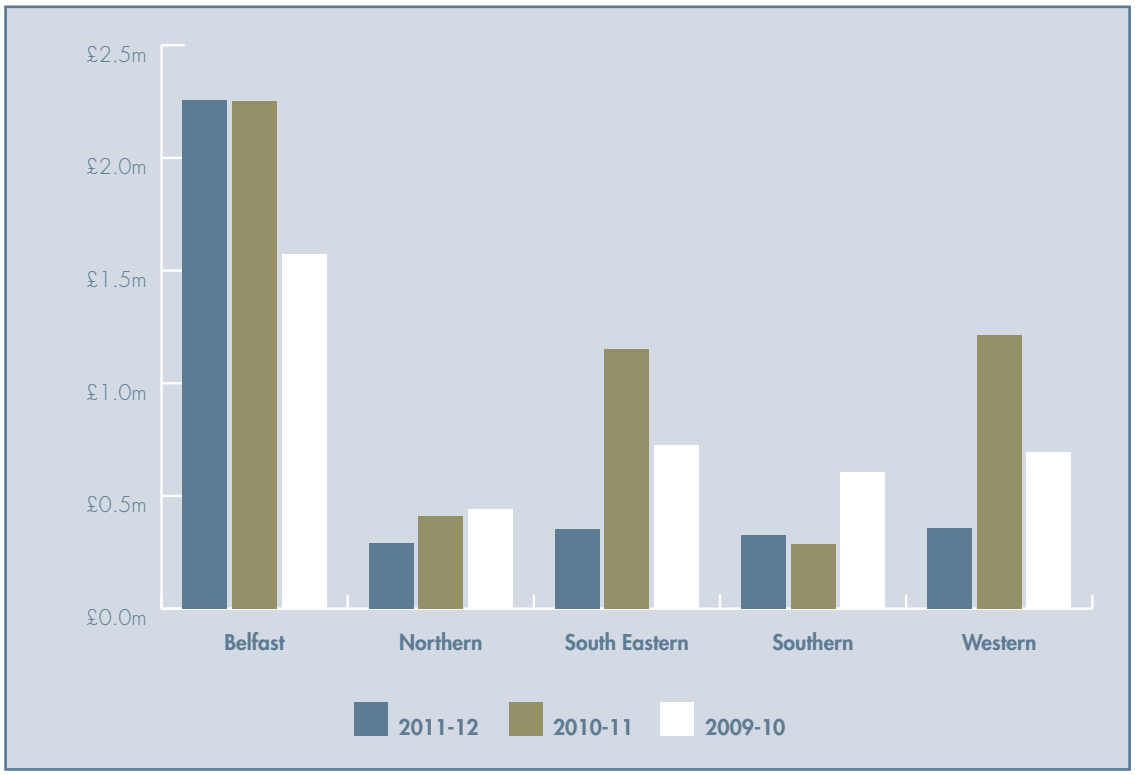
23 Stipulated suppliers may be defined as suppliers for which a strong preference is expressed for their particular product/service in a situation where other suppliers have goods or services with similar qualities on offer. Examples might include medical products where a clinician specifies a particular product as being more effective for an individual patient but where other suppliers can offer similar products which may be equally efficacious for the generality of patients.

Figure 17: NI Performance - Use of Single Tender Actions (Stipulated Supplier) by value 2006-07 to 2011-12



Source: Business Services Organisation

Figure 18: Trust Performance - Single Tender Actions (Stipulated Supplier) Expenditure 2009-10 to 2011-12



Source: Business Services Organisation

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Issues arising from the 2011-12 audits of HSC bodies

Non-adherence to EU procurement rules - Qualification of BSO Financial Statements

4.5.1 BSO provides a range of business support and specialist professional services to the HSC sector. One of these services is the supply of a procurement and logistics service (PaLS). BSO PaLS is recognised as a CoPE established under the Northern Ireland Public Procurement Policy as approved by the Northern Ireland Assembly.

4.5.2 Internal Audit examined BSO PaLS contract management procedures in 2011-12 and provided a limited assurance[24] opinion. The opinion was limited because of:

- the use of roll forward contract arrangements and pricing agreements rather than competitive tendering processes; and
- issues surrounding PaLS's system to monitor contracts, so that those due to expire would be highlighted in a timely manner. PaLS manages approximately 1,500 contracts.

4.5.3 The BSO 2011-12 financial statements have been qualified. We estimated that HSC bodies had incurred expenditure of £2.5 million through BSO on PaLS contracts which were potentially in breach of the Public Contract Regulations (2006). Over the period 2007-08 to 2010-11 we estimated a further £3.6 million had also been spent which was potentially in breach of the regulations.

4.5.4 HSC bodies can use the BSO PaLS contracts to make purchases directly from suppliers with no impact on the BSO's accounts. The effect of the contracts in question therefore extended beyond the BSO. Although HSC bodies hold financial information for each supplier, they do not break this down to individual contracts. To have obtained this information from current Health Sector IT systems would have been very costly. Using BSO records, it was estimated that the likely direct expenditure by HSC bodies on the potentially irregular contracts, which had been extended beyond their term, was not material.

4.5.5 It is concerning that BSO PaLS, as a CoPE, has contract management procedure weaknesses and does not appear to have applied the lessons to be learned from the procurement issues highlighted previously by the Public Accounts Committee in the wider public sector and elsewhere in the health sector[25]. We also note that the corporate governance processes within BSO did not highlight these issues and the matter was only escalated through the governance system when reported on by Internal Audit.

4.5.6 In respect of the potential impact on value for money of contract extensions, BSO stated that prices secured within

24 A Limited Internal Audit Assurance opinion means there is considerable risk that the system will fail to meet its objectives. Prompt action is required to improve the adequacy and effectiveness of risk management, control and governance.

25 PAC report on Procurement and Governance in Northern Ireland Water (NIA 40/10/11R: 3rd February 2011) and the Financial Auditing and Reporting General Report by the Comptroller and Auditor General for Northern Ireland - 2011, (PC2964 10/11: 25th October 2011).

the terms of the extensions compare favourably with national benchmarks. BSO advise that a number of the contract extensions were secured in order to enable tender strategies to be developed and implemented to deliver improved value for money.

4.5.7 BSO have stated that remedial action is being taken to source the products which are within the extended contracts. In addition to a programme centring on open tender competitions, from June to September 2012 BSO PaLS engaged with NHS Supply Chain to re-source supply for a range of products for an interim period. However, the products concerned cost £7.2 million at prevailing BSO PaLS prices, whereas the NHS Supply Chain catalogue showed a cost of £8.3 million. As the NHS Supply Chain did not offer a value for money solution on these contracts BSO PaLS have proceeded with plans to locally let tenders for the contracts.

4.5.8 The Department has told us that in parallel with the BSO's internal work, it has led two exercises:

- the Department's Head of Internal Audit has co-ordinated a review utlilising BSO Internal Audit resources to identify the root causes of the non-compliant contracts and to evaluate related BSO governance arrangements. The review's term of reference called for all extended contracts managed by BSO PaLS to be scrutinised (with an analysis of the reasons for extension), a study of the relevant governance arrangements (including management's assessment of contract information and risk), and an appraisal of BSO/ PaLS's implementation of relevant recommendations from the Procurement Review. The Department expects to receive the BSO response to the review recommendations shortly; and

- the Department has set up a four member "Procurement Oversight Group" (POG) including two experts independent of DHSSPS. The Group's remit is to:

  - assess the realism and adequacy of the action plan put forward by BSO PaLS and monitor its implementation;

  - consider in-depth the BSO PaLS response to the key strategic issues identified by the BSO and Departmental internal audit, and NIAO findings; and

  - confirm that all relevant internal audit, NIAO departmental and DFP policies, good practice recommendations etc on procurement and contract management are appropriately implemented.

The Department anticipates the lessons learned from both exercises will be applied before the end of the 2012-13 financial year.

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Key points and recommendations

4.6.1 Key points to note are:

- Health and Social Care (HSC) bodies procured expenditure of £750 million in 2010-11 and £773 million in 2011-12. (paragraph 4.1.1)
- The Department of Health, Social Services and Public Safety's (the Department) review of procurement across HSC bodies found that while explicit assurance was generally forthcoming on the due operation of procedures and control systems, bodies were less willing to rule out the potential existence of individual cases of non-compliance. In the area of service and maintenance contracts, it is expected to take three to five years before comprehensive compliance can be ensured. (paragraph 4.3.3)
- The HSC procurement review made 26 recommendations. Progress on implementation of these recommendations will be reported to the HSC Regional Procurement Board. We will continue to monitor progress within this very significant area. (paragraphs 4.3.5 and 4.3.6)
- In February 2012 the Department issued new guidance to its Arms Length Bodies (ALBs) on their use of Single Tender Actions (STAs). The guidance provided clarification on the roles and responsibilities of the Department, ALBs and Centres of Procurement Expertise (CoPEs), and introduced new procedures to tighten the controls surrounding the use of STAs. We welcome actions taken to tighten controls in this area. (paragraphs 4.4.2 and 4.4.3)
- STA (stipulated supplier) expenditure across the HSC sector has fallen from a peak of £9.8 million in 2006-07 to £4.0 million in 2011-12. (paragraph 4.4.4)
- The largest users of STAs are the five non-regional Trusts and there is a mixed picture year on year on their usage of STAs. (paragraph 4.4.5)
- The Business Services Organisation (BSO) 2011-12 financial statements have been qualified. We estimated that HSC bodies incurred expenditure of £2.5 million through BSO Procurement and Logistic Service (PaLS) contracts which were potentially in breach of the Public Contract Regulations (2006). (paragraph 4.5.3)
- It is concerning that BSO PaLS, as a CoPE, has contract management procedure weaknesses and does not appear to have applied the lessons to be learned from the procurement issues highlighted previously by the Public Accounts Committee in the wider public sector and elsewhere in the health sector[26]. (paragraph 4.5.5)

26 PAC report on Procurement and Governance in Northern Ireland Water (NIA 40/10/11R) published 3rd February 2011 and the Financial Auditing and Reporting General Report by the Comptroller and Auditor General for Northern Ireland – 2011, (PC2964 10/11: 25th October 2011).

- With the potential regularity and litigation risks associated with poor contract management, added to the potential value for money rewards arising from improvement:

  - we welcome the progress made by Trusts in this area in 2011-12. Trusts should continue to focus on the effective management of contracts and ensure that all improvements noted in 2011-12 are sustained. (paragraphs 4.2.1 and 4.2.2)

  - BSO and the Department should continue to address the contract management weaknesses identified in 2011-12. (paragraphs 4.5.7 and 4.5.8)

Section 5:
Belfast Health and Social Care Trust – Special Measures

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Belfast Health and Social Care Trust – Special Measures

The Need for Special Measures

5.1.1 On 11 April 2012, the Belfast Health and Social Care Trust (the Trust) was informed by the Department of Health, Social Services and Public Safety (the Department) that the Minister had asked for a series of special measures *"to be put in place, with the intention of increasing the Department's oversight of the Trust"*. The decision to do so arose after a number of significant events undermined Ministerial confidence in the robustness of the Trust's internal control systems.

5.1.2 The purpose of special measures was to give the Trust the opportunity to demonstrate, and restore Ministerial confidence in, the effectiveness of its operational controls. Ongoing progress assessments would be used to determine the degree of improvement in areas of concern to achieve improvement in the quality of service the Trust provides[27].

Events Leading up to the Introduction of Special Measures

5.2.1 A summary of the main events which resulted in the introduction of special measures is as follows:

- In June 2011, an Independent Inquiry commissioned by the Minister concluded that serious deficiencies had occurred in the quality of care provided to patients recalled for review appointments by the School of Dentistry and the Belfast Trust. This resulted in a short-life Working Group being convened to draft an action plan around the Inquiry's 45 recommendations;

- The Trust experienced an increase in the number of 12 - hour wait breaches[28], as a result of sustained pressure on the A&E Departments in March 2012. Wider concerns around patient management also arose at this time, which led to the establishment of project groups to examine, learn lessons and improve the acute medical intake process and to develop arrangements for effective care of the elderly;

- On 17 January 2012, an outbreak of the *Pseudomonas aeruginosa* infection was declared within the neonatal unit of the Royal Jubilee Maternity Service in Belfast. While the Trust collaborated with other relevant groupings in taking action to bring the outbreak under control, three neonatal fatalities were attributed to the infection, as was a fatality at Altnagelvin Hospital in Londonderry. The Minister subsequently commissioned an Independent Expert Group[29] (chaired by Professor Patricia Troop) to report on the circumstances leading to these four deaths. The Trust separately

27 The Trust's key business documents include the Trust Delivery Plan (showing how the Trust will deliver against the Commissioning Plan targets and priorities – paragraph 3.1.5) and the Service and Budgetary Agreement, which contain targets, standards and related guidance.

28 There is a four hour and 12-hour target in relation to unscheduled (emergency) care (see paragraphs 3.4.1 to 3.4.6). Since April 2010, Trusts and the Health and Social Care Board have had a responsibility to ensure that 95 per cent of patients attending any A&E Department are either treated and discharged home, or admitted, within four hours of their arrival. No patient should wait longer than 12 hours.

29 Independent Review of Incidents of *Pseudomonas aeruginosa* Infection in Neonatal Units in Northern Ireland, RQIA: Interim Report - 31 March 2012; Final Report - 31 May 2012.

commissioned a Root Cause Analysis investigation, the outcomes of which concurred with the Expert Group's findings; and

- Following identification of the need to carry out a fundamental review into the commissioning of the NI Regional Paediatric Congenital Cardiac Surgery Service (which falls within the Belfast Trust's remit), an Independent Expert Panel was set up in April 2012 to progress this work. The Panel's focus was on current service provision in terms of activity, outcomes and sustainability, and providing assurance on the Service's quality. In its July 2012 report[30], the Panel concluded that the Service, in its present form, was no longer sustainable, mainly due to low activity levels (although no immediate safety concerns existed).

Requirements under Special Measures

5.3.1 During the period of special measures, the Trust was required to update the Department monthly on progress against the main Ministerial standards and targets set; on specific milestones for improvement (arising from the events already detailed); and on other related aspects. These took the form of a comprehensive Action Plan, with deadlines and outputs linked to the completion of specific actions.

5.3.2 The seven specific areas of concern for progression through the Special Measures Action Plan included:

- recommendations of the Dental Inquiry;
- unscheduled (Emergency) Care Targets;
- lessons learned from Investigations of Serious Adverse Incidents in Emergency Departments;
- recommendations from the *Pseudomonas aeruginosa* Review;
- outcomes from the Review of the Paediatric Congenital Cardiac Surgery Service;
- implementation of Quality Improvement and Cost Reduction Plan 2012-13; and
- improved timeliness of communication and escalation of issues.

5.3.3 Progress monitoring on the Action Plan was facilitated through more frequent Governance and Accountability meetings which have been held monthly since May 2012. Attendees include Departmental officials, the Trust Chairman and the Chief Executive, supported by the Health and Social Care Board (HSCB) and the Public Health Agency (PHA). In addition to scrutiny of the Trust's progress reports and the HSCB's performance management

30 Review of the Paediatric Congenital Cardiac Service – Belfast Health and Social Care Trust – 2 July 2012.

Section 5:
Belfast Health and Social Care Trust – Special Measures

role, arrangements to strengthen key aspects[31] of corporate governance and accountability remain under consideration, alongside the clarification of emerging issues and the determination of any further action required.

Progress Recorded

5.4.1 Five monthly meetings have taken place under the special measures arrangements. Based on our examination of the related meeting documentation provided by the Trust and the Department, we note that all areas listed for progression continue to be addressed; achievements have been recorded in detail; and where further work on unresolved issues is required, specific actions and timescales for completion fall to the responsibility of named officials.

5.4.2 The Department is content that generally the Trust has made progress across the seven specific areas of concern which instigated the introduction of special measures in April 2012 including that the reduction in the number of 12 hour breaches to low single figures has been maintained. The Health and Social Care Board is also satisfied that Emergency Department performance has progressed satisfactorily. In November 2012 the Minister decided that the special measures arrangements should be relaxed. The Department will continue to monitor all of these issues through normal monitoring processes while the HSCB as Commissioners would continue to pay close attention to the performance of the Belfast Trust through its Trust performance management arrangements.

Key points and recommendations

5.5.1 Key points to note are:

- Special measures were introduced for the Belfast Trust in April 2012 to give the Trust the opportunity to ensure an improvement in the quality of service it provides and restore Ministerial confidence in the effectiveness of its operational controls. (paragraph 5.1.2)
- The events which resulted in the introduction of special measures in the Belfast Trust included:
  - Breaches in 12 hour waits at A&E Departments within Belfast Trust;
  - January 2012 – outbreak of the *Pseudomonas aeruginosa* infection was declared within the neonatal unit of the Royal Jubilee Maternity Service in Belfast. Three neonatal fatalities in Belfast were attributed to the infection. Two reviews were undertaken and action plans to implement the recommendations were formulated. (paragraph 5.2.1)

31 The monitoring of corporate governance and accountability arrangements focuses on: corporate documentation and oversight effectiveness; performance and procedural quality; and Action Plan milestones linked to resources and service delivery and improvement.

- Progress on the Belfast Trust Special Measures Action Plan was monitored through monthly Governance and Accountability meetings. (paragraph 5.3.3)

- In November 2012 the Minister decided that the special measures arrangements should be relaxed although the Department and the Health and Social Care Board will continue to monitor the Belfast Trust's performance closely. We will review this development in the 2012-13 audit of the Belfast Trust. We recommend that management in the remaining Trusts also take steps to ensure that the monitoring of the robustness of internal control systems, alongside corporate governance and accountability arrangements, is managed as a key operational priority. (paragraph 5.4.2)

Section Six:
Implementation of Agenda for Change – a pay modernisation programme

Section Six:
Implementation of Agenda for Change – a pay modernisation programme

6.1.1 Expenditure on salaries and wages in the Health and Social Care (HSC) sector currently exceeds £2.1 billion (Figure 19).

Figure 19: HSC Payroll Expenditure

	Payroll expenditure	
Health Body	**2010-11 £'m**	**2011-12 £'m**
Belfast Health & Social Care Trust	693	694
Northern Health & Social Care Trust	370	361
South Eastern Health & Social Care Trust	297	304
Southern Health & Social Care Trust	316	315
Western Health & Social Care Trust	310	319
NI Ambulance Service Health & Social Care Trust	41	48
Health & Social Care Board	23	21
NI Medical & Dental Training Agency	4	4
NI Blood Transfusion Service	6	6
NI Guardian Ad Litem Agency	3	3
Business Services Organisation	32	34
Public Health Agency	13	15
Patient & Client Council	1	2
Regulation & Quality Improvement Authority	6	6
NI Social Care Council	2	2
NI Practice & Education Council	1	1
Total gross expenditure	**2,118**	**2,135**

Source: HSC 2010-11 and 2011-12 accounts

6.1.2 We previously reported in 2010[32] on the HSC sector's progress on implementing the national Agenda for Change (AfC) agreement - a pay modernisation programme introduced in 2004 for 59,000 staff that aimed to bring about new ways of working which would contribute to improved patient care and more efficient delivery of services.

6.1.3 We noted in 2010 that:

- all 2009-10 staff annual performance reviews were to be underpinned by the AfC's 'Knowledge and Skills Framework'; and
- the Department planned to undertake a 'benefits realisation review' to measure the effects of AfC.

Implementation of the Knowledge and Skills Framework has been delayed

6.2.1 The AfC's Knowledge and Skills Framework (KSF) is intended to form the basis of annual staff development reviews and the resulting personal development plans. It is a tool for staff development, which in turn will lead to the delivery of improved services for patients, and has links to career and pay progression. At two defined points on the pay band, known as 'gateways', access to higher pay points will depend on demonstrating the application of knowledge and skills to a defined level for the post.

6.2.2 Under AfC, the gateway system was to become fully operational when an employer had put in place reasonable arrangements to ensure that staff have access to development reviews, personal development plans and appropriate support for training and development to meet the applied knowledge and skills required at the gateway concerned. The Department informed us that HSC employers are in the process of rolling out KSF but that it is not fully in place. To speed up this implementation process the Department informed us that employers have been advised that action may be taken to simplify the KSF process but the overarching principle remains that staff must have a development review and personal development plan in place. It also stated that the first gateway point at the bottom of the pay scales has been left 'open', with all staff progressing to the next pay point after one year of being in post. In addition the second gateway, due to be considered when the employee has reached the pay point before the maximum of the pay band, cannot be withheld in the absence of the KSF being in place with all staff progressing through to the maximum pay point.

32 General Report on the Health and Social Care Sector by the Comptroller and Auditor General for Northern Ireland 2009, (PC 2741 06/10: 30th June 2010).

Section Six:
Implementation of Agenda for Change – a pay modernisation programme

Job evaluations are ongoing and approximately a fifth of AfC staff requested a review of their pay band

6.3.1 In implementing AfC, each HSC body was required to evaluate all jobs, either through matching to national NHS job profiles or by local job evaluations. The job evaluation 'score' determined the job's pay band, and the new rates of pay for all AfC staff commenced on 1 October 2004. The agreement also allowed individual staff the right to seek a review if they had evidence to show that the grading allocated to them was incorrect.

6.3.2 By December 2012 12,125 staff (representing 99.9 per cent of the staff who had requested development reviews) had their reviews completed. The review outcomes were:

- 48 per cent (5,792 staff) remained on the same pay band;
- 46 per cent (5,570 staff) went up a pay band; and
- the remaining six per cent of staff were earmarked for full job evaluation.

Of the 5,570 staff who received a higher pay banding, 5,544 had their arrears paid by December 2012.

6.3.3 In August 2011 the Joint Negotiating Forum[33] reached a 'collective agreement' on the application of a higher grading following a review of staff undertaking identical duties to those staff where the AfC pay band had increased following a review. It also instructed the Trusts to compare AfC grades for staff from their legacy organisations (under the Review of Public Administration there were Trust mergers, with 19 becoming six in April 2007) to ensure grading consistency.

Staff are challenging the decision not to backdate pay to 1 October 2004

6.4.1 HSC staff applying for an increased pay banding under the collective agreement were to have their cases examined to see if their duties were identical to colleagues who had their pay band uplifted as a result of a successful review. By September 2012 a total of 1,901 collective agreement applications had been received and assessments are continuing. Where an upgrading of pay as a result of these reviews has occurred, it has been backdated to 1 October 2008 under the collective agreement. However, some individuals are challenging this through Industrial Tribunals on the grounds that the increased pay band should be implemented from 1 October 2004 (the date of implementation of the AfC pay bands). The Department told us that only one HSC body included a provision in its accounts in anticipation of the liability arising from the awards of AfC arrears of pay to staff. The provision is £15,000.

33 The Joint Negotiating Forum, consisting of HSC employers and recognised trade unions, oversees the local application of the national pay and conditions of employment for non medical staff.

AfC has resulted in substantial additional payroll costs

6.5.1 The Department informed us that it provided Trusts with additional funds for pay modernisation under AfC since 2004-05 including £113.6 million for 2011-12 (Figure 20).

Figure 20: Agenda for Change funding to the Health and Social Care Sector

Year	Funding
2004-05	£22.8m
2005-06	£57.7m
2006-07	£79.6m
2007-08	£94.6m
2008-09	£110.6m
2009-10	£110.6m
2010-11	£113.6m
2011-12	£113.6m
TOTAL	**£703.1m**

Source: DHSSPS

A formal AfC benefits realisation review will follow its full implementation

6.6.1 AfC was expected to bring about new ways of working which would contribute to improved patient care and to more efficient delivery of services. These benefits were listed among the AfC's 10 'success criteria'. HSC employers were asked at the end of 2009 to establish a system for measuring progress since the introduction of the AfC agreement, and put in place processes to facilitate the measurement of outcomes. The Department informed us that difficulties in undertaking a benefits realisation review of AfC include:

- there was no agreed timetable when HSC employers would implement AfC in each of the specific jobs;
- there has not been a 'steady state' over the AfC implementation period e.g. the Review of Public Administration and other initiatives have impacted, and brought about changes in the HSC; and
- AfC implementation is not yet complete.

6.6.2 The Department also informed us that a benefits realisation framework, agreed between the HSC employers and trade unions, emphasises that improvements in human resources must be measured by, among other things, staff turnover, absenteeism and the levels of grievances. It proposes to commence a pay audit, a requirement of the AfC agreement, in January 2013 when the review process is complete. The Department added that the equal pay audit framework will be agreed with regional Trade Union representatives. The pay audit will be conducted by employers in partnership with local Trade Unions.

Section Six:
Implementation of Agenda for Change – a pay modernisation programme

Key points and recommendations

6.7.1 Key points to note are:

- We noted in 2010 that:
  - all 2009-10 staff annual performance reviews were to be underpinned by the Agenda for Change's (AfC) 'Knowledge and Skills Framework'; and
  - the Department of Health, Social Services and Public Safety (the Department) planned to undertake a 'benefits realisation review' to measure the effects of AfC. (paragraph 6.1.3)
- NIAO considers that the important role the Knowledge and Skills Framework (KSF) was envisaged to play in the AfC agreement is not yet being realised due to ongoing delays in its implementation. (paragraphs 6.2.1 and 6.2.2)
- In implementing AfC, each HSC organisation was required to evaluate all jobs. Staff had the right to seek a review if they had evidence to show that the grading allocated to them was incorrect. From the 12,129 staff seeking a review 46 per cent went up a pay band and six per cent were earmarked for full job evaluation. (paragraphs 6.3.1 and 6.3.2)
- The Department told us that only one HSC body included a provision in its accounts in anticipation of the liability arising from the awards of AfC arrears of pay to staff. The provision is £15,000. (paragraph 6.4.1)
- The Department informed NIAO that it provided the Trusts with £113.6 million for pay modernisation under AfC in 2011-12. (paragraph 6.5.1)
- At the end of 2009 HSC employers were asked to establish a system for measuring progress since the introduction of the AfC agreement, and put in place processes to facilitate the measurement of outcomes. The difficulties in undertaking a benefits realisation review of AfC include:
  - there was no agreed timetable for when HSC employers would implement AfC in each of the specific jobs;
  - there has not been a 'steady state' over the AfC implementation period e.g. the Review of Public Administration and other initiatives have impacted, and brought about changes in the HSC; and
  - AfC implementation is not yet complete. (paragraph 6.6.1)
- We consider that an initiative of this importance and cost to the HSC must deliver, and demonstrate it has delivered, the intended benefits. It appears that to date, while the substantial costs of AfC have been incurred, few of the benefits of AfC are evident including the formal staff development, and resulting improvements in the delivery of services to patients, which the KSF has yet to secure. (paragraph 6.6.2)

Section Seven:
Counter Fraud and Probity Services

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Counter Fraud and Probity Services

Introduction

7.1.1 In the Health and Social Care (HSC) Sector, fraud[34] is generally classified into four main groups:

- Patient fraud – can include claims for free or reduced cost dental/ ophthalmic treatment when there is no entitlement; and fraudulently attempting to obtain prescription medication either for personal use or resale.
- Staff fraud - can include HSC staff submitting false claims for hours worked, travelled or subsistence; and falsifying qualifications to obtain employment.
- Family Health Services[35] fraud – can include altering prescriptions, substituting expensive drugs with a cheaper alternative but claiming for the expensive one; claiming for services or treatments that were not provided; and creating 'ghost' patients.
- Supplier fraud – can include submitting false invoices for goods or services not received; and offering a personal incentive to secure a contract.

7.1.2 The true extent of fraud against the HSC sector is unknown. With HSC gross expenditure of £4.4 billon (2011-12), the Counter Fraud and Probity Services (CFPS) 2010-11 Annual Report notes that even a one per cent loss would be over £40 million of the healthcare budget.

HSC counter fraud and probity services were brought together in 2009

7.2.1 In April 2009, as a result of the Review of Public Administration, the operational and policy aspects of counter fraud and probity services in the HSC sector were brought together in the newly established HSC Business Services Organisation (BSO). The CFPS has three main operational functions:

- probity services in Primary Care – providing a range of technical verifications and assurances to the HSC Board in relation to Family Health Services expenditure[36];
- counter fraud services across all HSC bodies – conducting investigations of cases of potential and suspected fraud involving HSC funds; and
- patient exemption verification in Primary Care – tackling patient exemption fraud, where patients wrongly claim to be exempt from statutory health charges.

In addition CFPS is responsible for:

- counter fraud and probity policy – including raising fraud awareness across HSC organisations;

34 The term fraud is commonly used to describe the use of deception, to deprive, disadvantage, or cause loss to another person or party. This can include theft, the misuse of funds or other resources or more complicated crimes such as false accounting and the supply of false information.

35 Family Health Services consists of General Practice, community pharmacies, dentists and ophthalmic services.

36 CFPS's Probity Service is one strand of the assurance framework for FHS expenditure e.g. other assurances are provided by the HSC Board's own verification processes and BSO payment processing business rules and other controls.

- the administration of the Healthy Start Scheme[37] in Northern Ireland; and
- notifying the Department, NIAO and the Department of Finance and Personnel of any reports of suspected or actual fraud in the HSC.

Counter Fraud and Probity Services' services and outputs

7.3.1 CFPS's service provision is partly routine, programmed activity, including probity services and patient exemption verification work, which is agreed and monitored through annual 'Service Level Agreement's' (SLAs) between BSO and the HSC Board; and partly reactive activity where its counter fraud work is dependent on notifications of suspected fraud. An indirect impact of CFPS will be a deterrent effect on some would-be fraudsters. CFPS informed us that in addition to delivering increased caseloads and levels of probity checking required through the annual SLAs, it delivers its share of BSO's spending review budgetary reductions.

Probity Services

7.3.2 Ten CFPS staff currently provide probity services in relation to Family Health Service (FHS) expenditure under a SLA between BSO and the HSC Board. Its verification and assurance work, undertaken on financial and other records underpinning payments to FHS practices/contractors, includes visits to GP practices and optometry premises; the verification of dental records against payment claims; and analysis of pharmaceutical payment data and medication checking clinics. In addition, CFPS has provided guidance to GP practices on the necessary record keeping required to support the claims for payment.

7.3.3 As well as providing the HSC Board with assurances on FHS expenditure, the probity work also identifies amounts for recovery due to errors by practitioners (ranging in 2011-12 from a few pounds up to £6,000[38]) and, where fraud is suspected, the referral of cases to counter fraud services for criminal investigation. The total recovered in-year by BSO Probity Services as a result of its work was £113,000 in 2011-12 from identified overpayments of £151,000 (Figure 21).

Figure 21: Overpayments identified/recovered as a result of CFPS activity in Family Health Service expenditure

	2009-10 £	2010-11 £	2011-12 £
Overpayments identified	'Figure not available'	66,000	151,000
Overpayments recovered in year[39]	80,000[40]	55,000	113,000

Source: CFPS

37 Specifically the reimbursement of Nurseries and Child Minders' for the supply of milk to the under-fives under the Day Care Foods element of the Healthy Start Scheme.

38 Where applicable, the period of investigation and recovery can extend back over payments made in previous six years (the statutory limit).

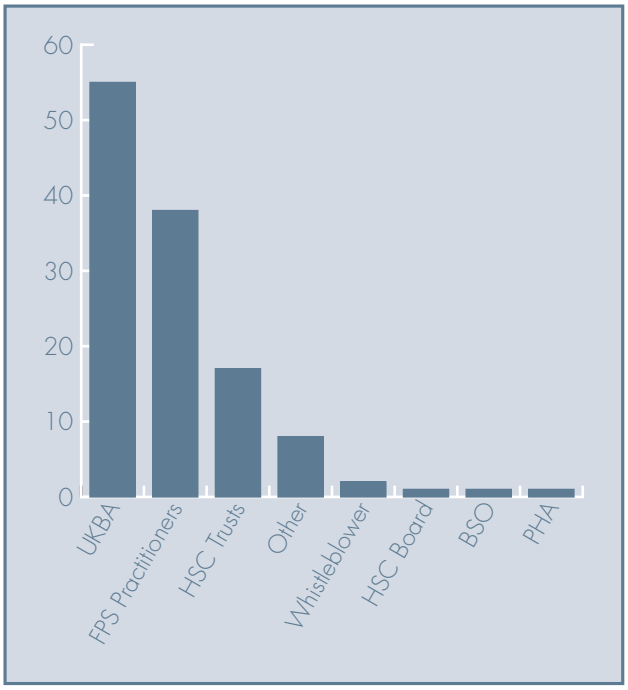
Section Seven:
Counter Fraud and Probity Services

Counter Fraud Services

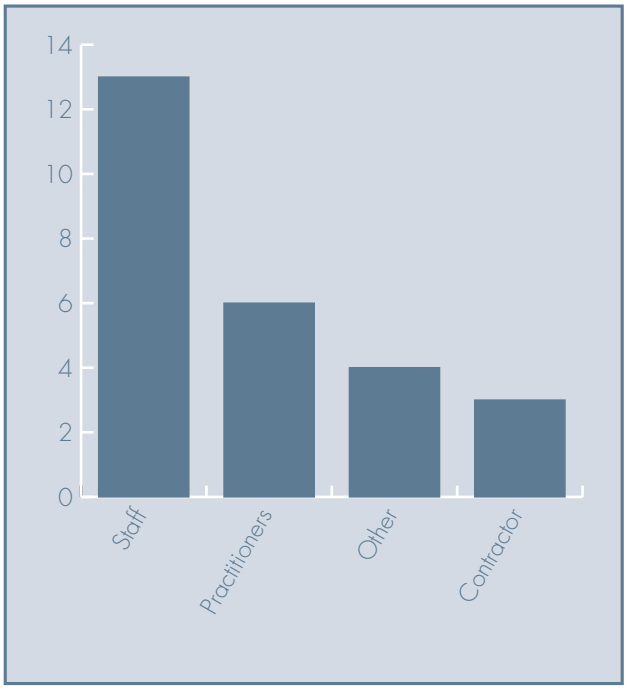
7.3.4 In November 2010, CFPS's remit for counter fraud services (fraud investigations) was extended, from solely primary care cases, for example involving FHS practitioners, to the entire HSC sector. Its current team of seven specialist investigators and support staff provide advice and undertake formal fraud investigations. These may lead to submissions to PSNI, and subsequent criminal prosecutions. An analysis of the 104 fraud referrals in 2011-12 to CFPS, by source and classification, is provided below (Figure 22). 39 of the referrals were joint investigations with the UK Border Agency (UKBA) regarding individuals who were suspected of being in Northern Ireland illegally, the majority of whom were found to have accessed free health service treatments for which they should have paid.

Figure 22: Analysis of Health Sector Fraud Referrals 2010-11 and 2011-12[39]

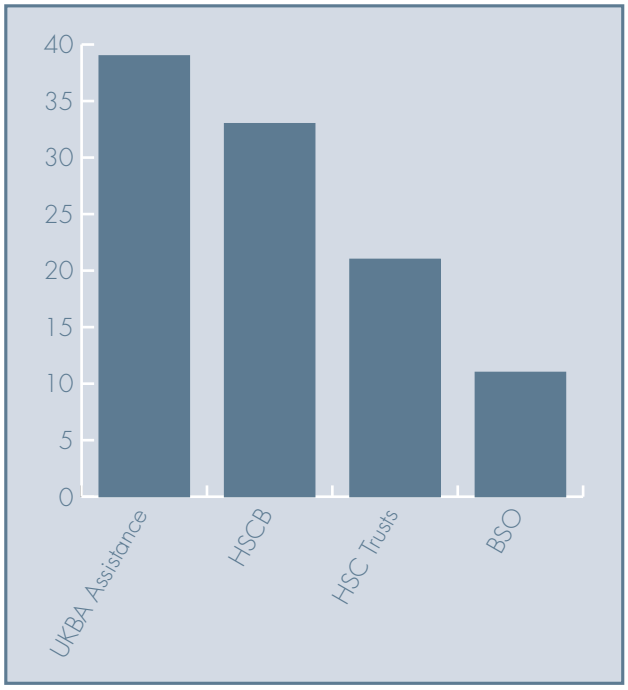
2010-11 Source of Fraud Referrals



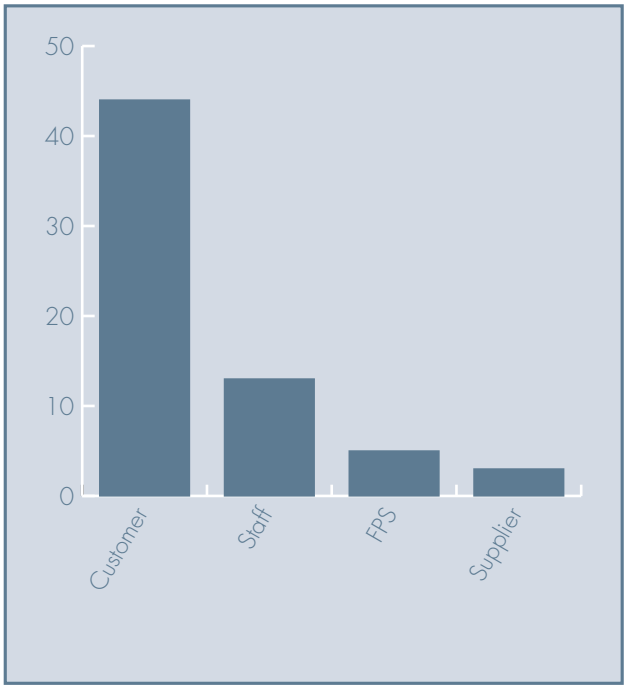
2010-11 Classification of Fraud Referrals



2011-12 Source of Fraud Referrals



2011-12 Classification of Fraud Referrals



Source: CFPS

39 The Department told us that a new case management system has been introduced in 2011-12 and it is not possible for CFPS to retrospectively revise the 2010-11 classifications

Section Seven:
Counter Fraud and Probity Services

7.3.5 CFPS's fraud investigations can be resource intensive and complex, and not all investigations will proceed to prosecutions. Investigations may find no fraud or insufficient evidence of fraud. However if overpayments are identified, these are notified to the appropriate client organisation for recovery. CFPS was not able to provide us with the number of cases it had investigated and closed, nor provide any analysis of cases, for 2009-10 (its first year of operation) due to limitations in its IT systems. We were informed that during 2009-10, CFPS was involved in four primary care investigations, one case of theft of HSC property and some nine cases, where patients sought to obtain prescription medication fraudulently.

7.3.6 CFPS has secured four successful prosecutions in the last two years (Figure 23):

- One suspect was convicted on nine counts of forgery and nine counts of fraud by false representation involving prescriptions. She was sentenced to 200 hours of community service; and
- One suspect was convicted of fraud by false representation, involving fraudulent requests for prescription medicines, and received a 12 month conditional discharge.

Figure 23: Summary of CFPS's criminal investigations for 2010-11 and 2011-12

	2010-11	2011-12
Investigations commenced by CFPS:	128	104
- joint investigations with UKBA[40]	55	39
- excluding joint investigations with UKBA	73	65
Investigation results		
- investigations closed by CFPS	74	49
- investigations passed to PSNI	17	9
- prosecutions	2	2

Source: CFPS

40 The joint investigations with the UK Borders Agency examined cases where persons not eligible for treatment were identified as accessing health service treatment free of charge. In each case the person's access to health service treatment free of charge was removed or stopped and where applicable these persons were charged for the treatment(s) received.

Patient Exemption Verification

7.3.7 Patient exemption fraud occurs when an individual claims exemption from paying the relevant statutory Health Service charges for dental or ophthalmic treatment, while knowing they do not qualify for exemption. Some patients make genuine errors in claiming exemption from health service charges. Independent estimates indicate there was £2.8 million of patient exemption fraud or error in 2011-12, an increase on the previous year's estimate of £2.2 million (which, if based on comparable 2011-12 activity levels, would rise to £2.6 million). The BSO Information Unit independently calculates the estimated level of patient exemption fraud in Northern Ireland and includes this in the BSO's annual financial statements. The calculations are based on the results from a statistically random sample of exemption checks carried out by CFPS.

7.3.8 CFPS undertakes both random and targeted checks on cases where patients claimed to be exempt from paying the relevant statutory Health Service charges. In addition to having to pay back the original charges those found not to be entitled to exemption from charges, can also be fined up to £100, with a further surcharge for non payment. CFPS told us that, in 2011-12, a total of 2,072 fixed penalties/surcharges were levied. During 2011-12, some £30,098[41] was recovered.

National Fraud Initiative

7.3.9 The HSC sector also participates in the National Fraud Initiative (NFI)[42], aimed at identifying potentially fraudulent claims and payments by comparing sets of data. The 2010-11 NFI exercise resulted in the HSC sector identifying some £126,000 in overpayments, the vast majority of which were classified as error and are being recovered[43].

Counter fraud and probity services IT systems

7.4.1 NIAO considers that CFPS's work should be supported by IT resources that facilitate the operational and strategic management of its activity and performance, as well as the management of individual fraud investigations. This should enable a shift from reactive to more proactive/targeted activity, with a likely increase in both the efficiency and effectiveness of CFPS's work.

41 Comprises original patient charges and charges (fixed penalties and surcharges) levied by CFPS.

42 The NFI is a UK wide data matching exercise designed to detect possible fraud and error. The second NFI exercise in Northern Ireland was based on 2010-11 data from 107 organisations. Outcomes were reported in – National Fraud Initiative (NFI): Northern Ireland, NIAO, June 2012.

43 The NFI 'secure web application' database (July 2012).

Section Seven:
Counter Fraud and Probity Services

Key points and recommendations

7.5.1 Key points to note are:

- The true extent of fraud against the HSC Sector is unknown. With HSC gross expenditure of £4.4 billon (2011-12), the Counter Fraud and Probity Services (CFPS) 2010-11 Annual Report notes that even a one per cent loss would be over £40 million of the healthcare budget. (paragraph 7.1.2)

- CFPS received 104 fraud referrals (notifications of possible/suspected fraud) in 2011-12. NIAO considers that the build up of a fraud referral and prosecution database will be a valuable resource in understanding the nature and trends in fraud in the HSC sector, in identifying the major areas of risk, and informing proactive measures aimed at tackling it. (paragraph 7.3.4)

- CFPS will have a deterrent effect on would be fraudsters. NIAO considers that it is important to ensure that the success of CFPS's counter fraud activity, as well as the National Fraud Initiative (NFI) is widely publicised throughout the HSC sector to ensure the maximum possible deterrent effect. (paragraph 7.3.1 and 7.3.9)

- In 2011-12 CFPS probity services recovered £113,000 in respect of payment claims made by Family Health Service (FHS) practitioners and counter fraud services recovered £30,098 from those who had fraudulently claimed exemption from health service charges. Given the huge size of the healthcare budget and independent estimates that on dental and ophthalmic charges alone fraud/error is estimated to be £2.8 million, we recommend consideration is given to ensuring CFPS have the appropriate level of resources. (paragraphs 7.3.3 to 7.3.8)

NIAO Reports 2012-13

Title Date	Published
2012	
Continuous Improvement Arrangements in the Northern Ireland Policing Board	20 March 2012
Invest NI: A Performance Review	27 March 2012
The National Fraud Initiative: Northern Ireland	26 June 2012
NIHE Management of Reponse Maintenance Contracts	4 September 2012
Department of Finance and Personnel - Collaborative Procurement and Aggregated Demand	25 September 2012
The Police Service of Northern Ireland: Use of Agency Staff	3 October 2012
The Safety of Services Provided by Health and Social Care Trusts	23 October 2012
Financial Auditing & Reporting 2012	6 November 2012
Property Asset Management in Central Government	13 November 2012
Review of the Efficiency Delivery Programme	11 December 2012
The exercise by local government auditors of their functions in the year to 31 March 2012	19 December 2012
2013	
Department for Regional Development: Review of an Investigation of a Whistleblower Complaint	12 February 2013
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Published by Corporate Document Services and available from:

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4c Heron Wharf
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