AUDIT COMMITTEE

Tuesday 8 January 2002
(*Afternoon*)

Session 1

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AUDIT COMMITTEE
1st Meeting 2002, Session 1

CONVENER

*Mr Andrew Welsh (Angus) (SNP)

DEPUTY CONVENER

*Mr David Davidson (North-East Scotland) (Con)

COMMITTEE MEMBERS

*Scott Barrie (Dunfermline West) (Lab)
Margaret Jamieson (Kilmarnock and Loudoun) (Lab)
*Paul Martin (Glasgow Springburn) (Lab)
Mr Lloyd Quinan (West of Scotland) (SNP)
*Mr Keith Raffan (Mid Scotland and Fife) (LD)

*attended

THE FOLLOWING ALSO ATTENDED:

Mr Robert Black (Auditor General for Scotland)
Gordon Smail (Audit Scotland)

CLERK TO THE COMMITTEE

David McGill

SENIOR ASSISTANT CLERK

Ruth Cooper

ASSISTANT CLERK

Seán Wixted

LOCATION

Committee Room 3

Scottish Parliament

Audit Committee

Tuesday 8 January 2002

(*Afternoon*)

[THE CONVENER *opened the meeting at 14:01*]

Items in Private

The Convener (Mr Andrew Welsh): I welcome members to the first meeting of the Audit Committee in 2002. I wish members of the committee, staff, everyone at Audit Scotland and the general public a very good and successful new year. We have apologies from Margaret Jamieson and Lloyd Quinan. I make my usual announcement about mobile phones and pagers—they should all be switched off.

Agenda item 1 is to seek the committee's approval to take items 3 and 4 in private. Is that agreed?

Members *indicated agreement*.

"Overview of the National Health Service in Scotland 2000/01"

The Convener: Item 2 is the Auditor General's report, which is entitled "Overview of the National Health Service in Scotland 2000/01". Members have copies of that document. I invite the Auditor General to brief the committee on his report.

Mr Robert Black (Auditor General for Scotland): As the report is the second overview of financial management in the national health service that I have presented to the Audit Committee, it provides the opportunity to examine some of the trends and continuing pressures year on year. I do not intend to go through the report in detail, but it might be worth putting a few points on the record.

First, although I am obliged to comment on areas of concern in the report, the overall financial stewardship in the NHS in Scotland continues to be of a high standard. The great majority of accounts were presented for audit on time and there were no qualifications on what might be called the core opinion on the accounts for any of the 51 trusts, health boards and special health boards in Scotland. This year was the first in which auditors were required to include a specific opinion on the regularity of transactions. I will return in a moment to a related matter.

The most significant issues fall under two main headings: financial performance and the primary care administration services, which are the services that are provided to the NHS in Scotland by the Common Services Agency. Under the heading of financial performance, it is important not to take one year in isolation. The report highlights that the NHS bodies in Scotland, particularly acute trusts, continue to have difficulties in breaking even at year end. That trend is of some concern.

Eight trusts failed to break even in 2000-01. They had accumulated deficits that totalled £54 million. By comparison, the eight trusts that failed to achieve that target in the previous year had deficits that totalled £30 million. Although there was a technical deficit in Lanarkshire that accounts for some of the difference, the overall position has deteriorated marginally. As in previous years, some trusts were dependent on non-recurring income to break even in 2000-01. Overall, there was evidence of continuing financial pressures on trusts, particularly the large acute teaching hospitals. From the informal information that we have available, it is likely that those pressures will continue.

In September, the Minister for Health and Community Care announced an extra £90 million of funding to help to deal with the pressures, of

which £68 million was allocated to health boards to assist the trusts within their areas, £11 million was directed specifically to clearing the back deficit at Tayside University Hospitals NHS Trust and £11 million was earmarked for winter pressures. Primarily, those sums of money were intended to ease the financial pressures by reducing the deficits that had been accumulated by 31 March 2001. As those sums are non-recurring, it is fair to assume that any individual trust that had a deficit in 2000-01 will face challenges in the current financial year because the systemic problems that it inherited continue.

I am sure that members will recall having a dialogue about how the accounts were presented, which arose as a result of my first overview report. It is still not possible to give an overall picture of the financial health of the NHS in Scotland because of the different bases on which trusts and boards present accounts. Some progress has been made on that over the past year, but we are not yet on a new footing. The health plan recognises the need for change and I understand that arrangements are being put in place to improve the situation.

It is important that the cash accounts for the Scottish Executive health department as a whole have been audited. Those accounts, which were laid in the Parliament last month—at the end of the calendar year—show a cash underspend of £168 million against a net budget of roughly £5 billion. There was a cash underspend for the NHS as a whole at year end. However, it is important not to read that across to the resource accounting overspends in individual trusts—it is difficult to make that direct comparison.

I turn briefly to the second major heading, which relates to services that are provided to the NHS by the CSA. Problems were experienced in 2000-01 in implementing a new computerised system for processing payments to pharmacists, which represent the largest of the four primary care payment streams—about £600 million, or 50 per cent of the total amount of such payments that are made each year in the NHS in Scotland.

A new computerised system for processing those payments to pharmacists was implemented by the CSA in 2000-01. Under the old system, where there were advance payments, the amounts were reconciled usually within about two months. There has been an extra three-month delay in determining the payment information, so the delay is now five months. The auditor of the CSA has drawn attention to the inherent risk in paying external contractors on an estimated basis for five months.

It is important to point out that the auditor of the CSA has also indicated that, so far, the potential losses that might be incurred as a result of difficulty in recovering overpayments are very small—less than £100,000. However, it is worth mentioning it as an area of risk that might become more serious in the future.

More significant is the other issue relating to the CSA, which has been carried over from the first overview report. The Audit Committee was concerned about delays in implementing a verification system for primary care payments. The nature and volume of primary care payments is significant. There are about 60 million transactions a year—payments to general practitioners, pharmacists, dentists and opticians that are valued at more than £1.2 billion. The committee will recall that the practitioner services division of the CSA manages the transactions.

There has been progress in putting verification procedures into place. However, during the financial year 2000-01, there were no formal agreements operating between the CSA and the primary care trusts. Inconsistencies remain in the operation of payments checks across Scotland. Only a limited number of GP practices were visited in 2000-01.

I mentioned the new requirement for an opinion on the regularity of transactions. An audit consequence of that is that there was a qualification of the regularity audit opinions of primary care trusts and most health boards. Auditors were unable to obtain sufficient evidence to be satisfied that primary care expenditure—payments to contractors—and income, which is the charges to patients, were being managed in accordance with all the guidance. For that reason, many auditors qualified the regularity opinions. We understand that good progress in being made in that area, but there was cause for concern in the previous financial year.

Those are the main issues to which I want to draw the committee's attention. Many other issues are mentioned in my report and I would be happy to answer questions on any of them.

The Convener: I congratulate the Auditor General on compacting 40 pages of detailed information and covering a great range of topics in such a precise fashion. You have drawn to our attention major problems that remain to be tackled and the committee will consider those in detail. The report is detailed and available to the public. On behalf of the public, I thank the Auditor General and Audit Scotland for their work.

We now move into private to consider the detailed questions that will form part of our public inquiry and the final draft of our further education overview report as a—

Mr Keith Raffan (Mid Scotland and Fife) (LD): Are we not allowed to ask the Auditor General questions on the report?

The Convener: I apologise. Perhaps I am a little ahead of myself. If the committee is keen, I would be the last person to prevent members from asking questions.

Mr Raffan: We have been upbraided elsewhere for not holding all discussions in public.

In respect of the CSA, following from last year, I worked out that the underspend was something like 3.5 per cent. Is that right?

Mr Black: It is about 3.3 or 3.4 per cent.

Mr Raffan: What was the underspend the previous year? Was it about the same?

Mr Black: I am sorry, but we do not have that information.

Mr Raffan: Is that par for the course?

Mr Black: No. That was a significant underspend last year. You may recall that Trevor Jones explained to you the nature of the cash accounting. It is purely a cash position at year end—it does not reflect commitments. Therefore the underspend may simply mean that invoices have not been cleared and so on. It is true that year on year the NHS tends to underspend in Scotland, just as it does in the United Kingdom as a whole.

Mr Raffan: That leads me to the second point, which is the definition of underspend, which may refer to money that is already committed, rather than money that is unallocated.

Mr Black: Absolutely. That is a difficulty. Resource accounting is different as applied to the trusts, because that includes commitments entered into where invoices are outstanding for the financial year in question.

Mr Raffan: So it is not really possible to put it into two categories: committed and not allocated.

Mr Black: When resource accounting is fully in place for all government expenditure—there was a move towards resource accounting this year—it should be possible to present a better and more consistent picture.

Paul Martin (Glasgow Springburn) (Lab): I have two points. On page 31, under the heading "Employment related matters", you touch on the model contracts that are in place for senior managers, chief executives, medical directors and so on. Are we satisfied that the trusts have enforced those model contracts? I ask that because I have not seen any evidence of that in the board papers. The report says that "a model contract" was introduced, but I am wondering whether that was enforced at board level.

There is also an issue about the review of pay and conditions in respect of those positions. At what stage is the evaluation of the senior management positions?

14:15

Mr Black: In paragraph 10.3, I make the point that auditors are satisfied that the health bodies have ensured compliance. We may not have information about whether such matters have been specifically considered at board level. My colleagues may have further information.

Gordon Smail (Audit Scotland): The auditors have considered the new arrangements and are satisfied.

Paul Martin: I have not seen any evidence. One would expect at board level people to discuss the reconfiguration of senior positions, as is the case in other levels. Porters, nurses and everyone else are experiencing that as a result of the deficits.

Mr Black: That may be a question that you can put to the appropriate witness.

Paul Martin: A completely separate point relates to the delay in payment verification. During our Glasgow visit, we questioned the Greater Glasgow Primary Care NHS Trust and found that there was an issue to do with visits to GP practices—only two visits had been carried out. Has there been any response on that? The health department was going to write to us to clarify what action it was going to take to deal with the fact that the committee found it unacceptable that only one or two visits were paid to GP practices at that time.

Mr Black: During the financial year in question, auditors found that there were still major gaps in post-payment verification, including practice visits. Our understanding is that an agreement in principle is now in place between the CSA and NHS bodies in Scotland about the way forward. However, that has not yet been fully implemented. That may also be an area in which it would be appropriate to ask questions of the health department and the CSA.

Mr David Davidson (North-East Scotland) (Con): People will be aware that some years ago I was a pharmacy contractor. I want to take up the point that the Auditor General made about the risk of overpayment to contractors. It is not a large sum of money and relates to the fact that those who go out of business will have been paid an estimate rather than a direct sum. However, people can also sell their businesses and then find that there is a back payment for which they no longer qualify. There is a rolling figure in there, which it might be useful to have at some stage.

More to the point, that issue flags up the fact that the Auditor General and Audit Scotland should be considering the contract between the health bodies and the contractors and everyone

else who is paid through the CSA system, to see whether there is a clause to ensure that actual sums are paid and that refunds are made where necessary. That is the system run by the environment and rural affairs department, where overpayments can be clawed back. In contrast, the pharmacy payments are clawed back through a pot system, rather than through individual contracts. Have you considered that contractual system in the health service?

Mr Black: That is a reasonable question to ask. I do not know whether the appointed auditor has examined the contract documentation, given the magnitude of the expenditure involved.

Gordon Smail: We would have to go back to the CSA for that information.

Mr Black: We will give the committee further information on that at a future meeting.

The Convener: On page 11, in the paragraph on whistleblowing policy, the report says:

"The Public Interest Disclosure Act 1998 … provides protection from dismissal and intimidation to employees who make disclosures in the public interest."

I note that not all health bodies have introduced a policy or are taking steps to develop appropriate procedures. The auditors recommended that early action should be taken. Can you tell us how many health authorities did not comply?

Gordon Smail: We do not have that information to hand. It is for the protection of the trust; it is best practice, rather than a legal requirement. It makes sense for information to be available to employees who wish to make a disclosure.

The Convener: Perhaps we can find that out. I have been a supporter of freedom of information since the 1970s, so I will explain that we are moving into private session only to consider questions for future public meetings.

14:20

Meeting continued in private until 15:22.

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