AUDIT COMMITTEE

Tuesday 5 March 2002
(*Morning*)

Session 1

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AUDIT COMMITTEE
4th 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

WITNESSES

Mr George Brechin (Fife Primary Care NHS Trust)
Mr Eric Harper Gow (Common Services Agency)
Mr Frank Owens (Scottish Pharmaceutical General Council)
Peter Peacock (Deputy Minister for Finance and Public Services)
Mr Tony Ranzetta (Fife NHS Board)

CLERK TO THE COMMITTEE

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Ruth Cooper

ASSISTANT CLERK

Seán Wixted

LOCATION

The Chamber

Scottish Parliament

Audit Committee

Tuesday 5 March 2002

(*Morning*)

[THE CONVENER *opened the meeting in private at 14:02*]

14:10

Meeting continued in public.

The Convener (Mr Andrew Welsh): I welcome everybody to the fourth meeting of the Audit Committee in 2002. I make my usual announcement about mobile phones and pagers—turn them off, please.

I have received apologies from Paul Martin, who is absent because of his duties on the Justice 1 Committee. There are no other apologies.

The committee opened in private today to consider the lines of questioning of witnesses under agenda item 2. That approach has been adopted by the committee throughout its inquiry into the report by the Auditor General on the "Overview of the National Health Service in Scotland 2000/01".

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

The Convener: We now move to agenda item 2. I welcome our witnesses—Mr Eric Harper Gow, the former acting chief executive of the Common Services Agency; Mr Tony Ranzetta, the chief executive of Fife NHS Board; Mr George Brechin, the chief executive of Fife Primary Care NHS Trust; and Mr Frank Owens, the chairman of the Scottish Pharmaceutical General Council. You are all very welcome. I believe that Mr Owens wishes to make a preliminary statement.

Mr Frank Owens (Scottish Pharmaceutical General Council): Thank you, convener. The Scottish Pharmaceutical General Council represents all Scottish community pharmacy contractors, be they high street chains or independent pharmacies. We negotiate their NHS remuneration and terms of service. To avoid confusion, I should say that we do not represent the pharmaceutical industry.

Pharmacy contractors need to have confidence in the system through which they are paid. Pharmacies are businesses and, like all businesses, they need accurate payments and they need information about those payments. In July 2000, the practitioner services division—PSD—of the Common Services Agency introduced a new computer system using optical character recognition. The SPGC was not actively involved in the decision to introduce OCR. In our view, it would have been more beneficial to the NHS to speed up the introduction of the electronic transfer of prescription data.

In its first year, the new system could not price prescriptions fast enough. That created many problems for the practitioner services division and consequently for community pharmacy contractors. The first problem was that pharmacists faced cash-flow problems. All contractors received estimated payments from the PSD, which frequently bore little relation to their actual expenditure. In many cases, the estimated payments were over-generous and excess payments had to be recovered from pharmacists at a later date. For an unfortunate few, the estimated payments were inadequate.

The second problem was that the timetable for the receipt of information was disrupted. To give an example, pharmacists would normally receive a statement for July prescriptions in October. As a result of OCR, they did not get that itemised statement until December. Without that information, contractors were unable to gauge the accuracy of the estimated payment, and it took some 18 months before contractors could once again be paid properly and in the normal time

schedule.

The third problem was the lack of transparency in the system. It took SPGC's experts up to two days to wade through one contractor's paperwork, just to establish the payment trail. That exercise would normally have taken only a few minutes. Those were our in-house experts, so what chance did an individual pharmacy contractor have?

The bottom line was that pharmacy contractors' confidence in the payment system was reduced. SPGC runs what we call a central checking unit, which makes sure that contractors are reimbursed properly for the medicines that they dispense. It does that by monitoring the quality of the pricing of NHS prescriptions. The checking unit aims to check a random sample of 3 per cent of all prescriptions. Since the introduction of OCR, our checking unit has found more errors than ever before. In our opinion, the overall error rate has doubled.

However, I finish on a positive note. The practitioner services division, and in particular the acting director, Richard Copland, have worked extremely hard to maintain a dialogue throughout this difficult period. I appreciate that.

14:15

The Convener: As none of the other witnesses want to make introductory statements we will continue with questions.

Mr Owens, you talked about disruption to the receipt of information, estimated payments that frequently bear little relation to expenditure, and over-generous payments. You also mentioned inadequate payments and lack of transparency in the system. Do you believe that suppliers are being treated fairly by the department?

Mr Owens: I am sorry, convener. What was the last part of your question?

The Convener: I was asking about the lack of transparency in the system. You pointed to major problems. Do you think that suppliers are being treated fairly by the department?

Mr Owens: Hopefully, we have managed to overcome many of those problems. The lack of transparency centred on the paperwork that we received about estimated payments. Little information was provided about how the estimated payments had been calculated. We had to take the estimated payments at face value.

The Convener: Very large sums of money are involved so there must be some risks. Do you believe that the monitoring information is too complex or too difficult to understand? Is there proper monitoring of what goes on?

Mr Owens: The pricing of NHS prescriptions is a complex procedure. There are 22,000 items in our own drug database and I believe that the pricing rules that are employed by the PSD currently run to something like several hundred manuscript pages. The magnitude of complexity is very great. However, we recognise those problems and we have tried to work with the PSD to overcome them.

The Convener: Do you have a clear view of how the system could be improved?

Mr Owens: Our biggest problem is the lack of transparency. Even in a normal payment schedule, there is very little information. The figures comprise reimbursement of drug costs together with professional fees. There is no breakdown of how those figures are arrived at, so we have to take them on good faith. However, you might argue that if you go into a supermarket, for example, to buy a bag of messages, you would receive an itemised receipt. A community pharmacy does not get that and therefore there is a lack of transparency in the system.

The Convener: Thank you for that general look at the system.

This is the third meeting at which the committee will be taking evidence on the financial stewardship of the NHS, based on the Auditor General for Scotland's 2000-01 overview report. So far, we have heard evidence about the financial position and performance in the NHS in Scotland.

Today, we focus on the primary care payment arrangements. That is a significant area of expenditure in the NHS in Scotland. In the year under review, expenditure was approximately £1.3 billion, accounting for over one fifth of NHS expenditure in Scotland.

The committee will consider two subjects. First, we will consider the problems experienced in implementing the new computerised system for processing payments to pharmacists. Secondly, we will consider the delay in implementing robust and consistent payment verification arrangements.

Mr Harper Gow represents the Common Services Agency as he is the accountable officer for the period covered by the report. The CSA is responsible for processing primary care transactions and making payments to primary care contractors, such as general practitioners, pharmacists, dentists and opticians, on behalf of the primary care trusts.

I begin the evidence-taking session by asking Mr Harper Gow a question on the first subject—the pharmacy payment system.

Paragraph 8.10 of the Auditor General's report tells us that there were problems in 2000-01 in implementing a new system for processing payments to pharmacists. What caused those

problems, how have they been resolved and what lessons have been learned?

Mr Eric Harper Gow (Common Services Agency): As members might expect, in 2000-01 we were faced with a range of problems. In the middle of 2000, when we introduced the new system, we were already four to six weeks behind the normal, historic pattern of pricing and payment. That was the result of a shortage of generic drugs, which meant that branded drugs were dispensed. Each prescription that involved the replacement of a generic drug by a branded drug had to be endorsed. We took action to engage additional staff, but we were not able to address the backlog fully. We started from the situation of being four to six weeks behind.

Why did we introduce a new system at that point? The data capture validation and pricing—DCVP—system, which has already been described as an OCR-based system, was designed to replace a 16-year-old system that had become unsupportable. In Scotland only four members of staff were able to operate in the programming language on which it was based—it was a very old system. Accordingly, it was decided that we needed to introduce a new system to ensure that we continued to price prescriptions, albeit with some delay. The new system was introduced in September 2000, to pick up dispensing from July 2000 onwards.

The system was 18 months late and was incomplete, but it could do the job that the old system did. However, our investment did not bring us the benefits that we were hoping for. Teething problems led to further delays in processing prescriptions. The system had been tested, but there had been no opportunity to carry out dual running. As a result, by 31 March 2001—the end of the period under review—we were three to four months behind, depending on the time from which the backlog was measured and on the health board area concerned.

The convener asked what we did about that. We devised and implemented a programme that we imaginatively termed “catch-up”. That required us to improve the robustness of the system that we were operating, so that we might avoid what technical people call single points of failure. We also wanted to increase the capacity of the system to enable it to handle twice the normal monthly volumes. That would allow us to achieve the catch-up programme, which we aimed to complete by 30 November. All tasks that were not essential to achieving catch-up were put on hold. We recruited temporary staff and trained them to a basic level. Our existing staff were retrained to operate in a different way, so that we could get through the work with the help of basically-trained temporary staff.

Catch-up was achieved on 29 November, so we met our deadline. I am pleased to say that, since then, processing is in accordance with the historic schedules.

The Convener: We will consider that matter in more detail shortly. How much more must be done to the system? Are you satisfied that the system is being adequately improved?

Mr Harper Gow: As it stands, the system is pricing prescriptions, enabling payments to be made to contractors and delivering the management information that we received previously and some additional management information that we wanted—although not all of it. We are now engaged in a programme that is designed to implement the further improvements to the system that were put on hold when we started the catch-up programme. We are also taking a number of other steps that will enable us to move forward. I would be happy to discuss those with the committee.

The Convener: How much more is to be done? How close are you to getting a system with which you would be satisfied?

Mr Harper Gow: We have a system that works and that does the job that we are required to do just now, but it has not introduced some of the benefits that we envisaged when we set out on this path in 1997-98, when the original specifications were drawn up.

Reference was made to the electronic transmission of prescriptions. Members might be aware that such a project is in progress under the aegis of the Scottish Executive health department. We have achieved catch-up and we are working on some of the immediate requirements for improving the system. We are also considering how best to integrate the OCR-based technology that we have with the electronic transmission of prescriptions project.

At present, we do not know where the end of the road is. We have a number of tasks to complete within the next six to nine months and we are working on those while the longer-term position is identified.

Mr David Davidson (North-East Scotland) (Con): Mr Harper Gow, you said that at one stage you got into a three to four-month delay. How long did you run the dual system—that is, the old system alongside the new? What made you change suddenly to the new system? When you had a problem, why did not you continue with the dual system until the new system was robust?

Mr Harper Gow: We introduced the new system when we were four to six weeks behind. That was in the middle of 2000. We did not do any dual running. In other words, we did not run the same

prescription through the old system and then through the new system because we had reached a situation where the 16-year-old system was no longer supportable and we believed that the new system could do the job. However, the new system had a number of teething problems and we fell behind over the winter of 2000-01 by a maximum of three to four months. Have I answered your question?

Mr Davidson: Yes. You mentioned dualling in your opening remarks and I wondered how long you had run that for because you did not define it.

Mr Harper Gow: No, I am sorry. I meant to say that we did not dual run. We tested the system fully before it was implemented—or we thought we had—but there was no period of running the old system in parallel with the new one. We had to switch off the old system. We did not have staff who were capable of running both.

Mr Davidson: You are saying that you could not run a dual system.

Mr Harper Gow: We could not run a dual system.

The Convener: Scott Barrie has a question that considers the problems of implementing a new computerised system for processing payments to pharmacists.

Scott Barrie (Dunfermline West) (Lab): Thank you, convener.

Mr Harper Gow, the problems that you encountered with the new system led you to make estimated advance payments to pharmacists. Are there currently any overpayments still to be repaid? If there are, how are you going about collecting them?

Mr Harper Gow: I am sorry, I did not quite catch the middle part of your question.

Scott Barrie: Are there any overpayments outstanding because of the way in which you had to make estimated payments when the system was not working?

Mr Harper Gow: Members might be aware that the concept of an estimated payment is not out of the ordinary in the way that pharmacists are paid by the NHS. I indicated that we have now resumed the normal timetable. That allows for prescriptions dispensed in January, for example, to be priced by the CSA during the latter part of the January and into February. An estimated payment equivalent to 90 per cent of what is thought to be due is made at the end of February on 30-day payment terms.

When all the reconciliations and so on are done, a further adjustment, taking account of the remaining 10 per cent and any pluses or minuses as a result of the reconciliations, will be made—in the example that I am using—at the end of March. That is the normal timetable. What happened when we went on to full estimated payments was that the 90 per cent payment at the end of month one became a 100 per cent payment.

14:30

Once we had a bit of a track record and had been doing that for a few months, we identified that the estimates were not as accurate as everyone would have liked. That meant we had to sit down with the profession and negotiate a change to the formula by which the estimates are calculated. We agreed a change to the formula, which reduced the inaccuracies considerably, both over and under. The position now is that the overpayments that we are attempting to recover from pharmacy organisations that are no longer in the business has been reduced to £153,000 out of an annual spend of between £700 million and £800 million.

Scott Barrie: Forgive me if I have not fully understood your explanation, Mr Harper Gow, but was the requirement to change the formula, which you undertook with the pharmacists, directly related to the problems that you were encountering with the delay in your new system, or was it due to an additional difficulty?

Mr Harper Gow: No. The formula was changed because we found that the historic method of calculating the 90 per cent estimate was not as accurate as we had previously believed it to be. Arguably, it was okay for calculating a 90 per cent estimate that you were going to catch up with the following month, but when the catch-up adjustment to actual figures took several months—three to four months, as I said earlier—it was felt by the contractors and the service to be unsatisfactory.

Scott Barrie: So are you saying that the difficulty had been around, but it had previously not been known about?

Mr Harper Gow: Yes.

Scott Barrie: My next question is for George Brechin. Clearly, the problems that Mr Harper Gow has mentioned impacted directly on primary care trusts. When did you become aware of the problems, and was there adequate consultation between your trust and other primary care trusts and the Common Services Agency on the decision to make estimated payments to pharmacists?

Mr George Brechin (Fife Primary Care NHS Trust): We became aware of the issue during the course of the financial year. There was fairly quick reporting back through the financial chain as the problems began to emerge. It was an issue that trusts throughout Scotland took seriously, and on which there were a number of meetings. Primary care trust chief executives meet regularly, and on

a number of those occasions we invited one of Mr Harper Gow's colleagues, Richard Copland, the acting director of practitioner services, to come and talk to us about the issues that were raised.

We were anxious—to put it mildly—that the problem be resolved as soon as possible. There were a number of reasons for that: first, the importance of maintaining the general pharmaceutical service; secondly, financial control; and thirdly, the requirement for management information for local health care co-operatives, which is a by-product of the financial control. The primary care trusts—not just at finance director level but at chief executive level—were involved and were urging the Common Services Agency to sort out the situation. We were reporting the matter to our trust boards and health boards as a major issue to be resolved, in particular in accounting terms for the year.

Scott Barrie: How significant a financial risk did the decision to pay on an estimated basis pose for the trusts?

Mr Brechin: The trouble that I have in answering that question is that one would normally assess a risk by past experience, but we did not have a lot of past experience of the new system to go by.

Primary care trusts worked very closely, especially at the finance level, to validate—no, validate is the wrong word—to ensure that we were confident in the approach that was used in making estimates and that we would be confident in the figures that would eventually be in our financial accounts. I think that that work was successful in that the estimates were relatively close to the actual figures. There was a significant risk, but much of that risk did not materialise. However, it was not a happy time.

Scott Barrie: I can imagine.

You say that the estimates were "relatively close", but can you tell us how close they were, as a percentage of the budget?

Mr Brechin: I will happily supply you with a detailed figure, if required. From memory, we were significantly less than £100,000 out in our estimates. In the accounts of the trust, the deviation was not material.

Scott Barrie: So your estimate was almost bang on—£100,000 in a budget of many millions of pounds.

Mr Brechin: As some of my colleagues know, I tend to translate figures into time. For a trust the size of the one that I am responsible for, £100,000 equates to about five hours' expenditure.

The Convener: How did consultation take place between yourselves and the CSA?

Mr Brechin: There are regular meetings of primary care trust chief executives and of primary care trust finance directors across Scotland. There are also meetings of people in the second line of the finance departments across Scotland. The issues that we have been discussing today were a topic at virtually every meeting. I think that finance directors meet monthly; chief executives tend to meet bi-monthly. The acting director of the practitioner services division attended meetings with chief executives, as I have said, on two if not three occasions, and attended virtually every meeting of the finance directors.

Mr Davidson: I would like to turn to Mr Owens, whom I thank for his opening statement. From my experience—I am a former practitioner—I would have added that pharmacies have to pay their bills before they know what they are getting reimbursed for. You strayed away from that point.

When was the Scottish Pharmaceutical General Council first aware of difficulties under the old system and what representations did you make to the CSA at that time?

Mr Owens: We became aware in April 2000 that the PSD's pricing timetable was beginning to slip. During April 2000, a number of contractors in the larger health board areas began to receive estimated payments.

The DCVP optical character recognition system came into play nationally with the pricing of July's prescriptions, but several months previously the pricing timetable had begun to slip. As I have said, some contractors in some parts of the country began to receive estimated payments considerably before we had to confront the situation nationally.

Mr Davidson: If the estimated payments went up, that, in theory, would improve your cash flow.

Mr Owens: I understand what you are saying. However, although some contractors may have received overly generous estimated payments, others received underestimated payments. It was difficult for people to determine their cash flow and to make financial forecasts.

Mr Davidson: Did many of the contractors whom you represent raise individual issues with the general council?

Mr Owens: Many did. We debated the issue at length in our organisation and we had a considerable number of meetings with the PSD. We decided that the best way in which to overcome the difficulty was to work as closely as possible with the PSD.

Mr Davidson: Did you feel that the consultation between you, as pharmacists and pharmacists' representatives, and the department and the primary care trust was adequate?

Mr Owens: The PSD was quite receptive. When we initially moved forward with the estimated payments, none of us had ever been in such a situation before. As Mr Brechin said, it was new territory for us.

We had to find a formula that allowed pharmacists to continue to purchase drugs on behalf of the national health service. Cash flow was an issue. The formula that the PSD came up with turned out to be overly generous, as we recognised fairly quickly, in the space of the first few months. We sought further meetings with the PSD to redefine that formula, which resulted in improved accuracy of estimates.

Mr Davidson: Were there any particular problems for individual pharmacy contractors? I am referring not simply to contractors who could not pay their bills because they had been underpaid by the department, but to contractors who accumulated overpayments that they did not realise were overpayments.

Mr Owens: There were difficulties in that, although funding was coming in, pharmacists were unsure as to whether they were entitled to it or whether it was enough. Other difficulties have since transpired, for example with accountancy fees. Because of our difficulties in identifying the accountancy paper trail from when accounts were handed over at the end of the financial year, accountants had great difficulty in interpreting the data and in drawing up sets of accounts.

Mr Davidson: Did the tax authorities take a fair view of the situation?

Mr Owens: The tax authorities?

Mr Davidson: The Inland Revenue.

Mr Owens: I am unable to comment, to be perfectly honest.

Mr Davidson: Do you know whether any representation was made by the department? Mr Harper Gow, did you participate in easing the accountancy problems that apparently developed?

Mr Harper Gow: I cannot answer about any contacts with the tax authorities—I am simply not aware of that. Accountancy problems were brought to our attention and, through one of our regular meetings with the Scottish Pharmaceutical General Council, we said that if any contractors had problems that they felt it would be helpful to discuss with us—in particular with the financial controller of the practitioner services division, we would be very happy to meet them for that purpose. A handful of them took up the offer. I am afraid that I cannot give you any further information on that.

Mr Davidson: Mr Owens, is there anything in the new system that gives you confidence in how fluctuations in the availability of generic drugs are dealt with?

Mr Owens: Fortunately, the situation with the supply of generic drugs has improved considerably over the past 12 months. As for the recovery, we are now back on the normal timetable.

I should add that there were some contractors who were underpaid during the difficulties, who had to go back to the banks to negotiate additional overdraft facilities.

Mr Davidson: Would you, on behalf of pharmacy contractors, like to make any further recommendations to the department as to how the system could be further improved?

Mr Owens: We have on-going concerns about the flexibility of the new system. There appear to be difficulties with regard to accommodating change. I am sure that members are aware that we are trying to develop new, better models of pharmaceutical care so as to improve the range of services that we offer our patients. Much of that work is established within the Executive's new strategy for pharmaceutical care. If we are to deliver on that strategy, we need to ensure that the existing infrastructure is capable of dealing with new methods of payment.

Mr Davidson: I take it that you have made recommendations to the department to that end.

Mr Owens: We have.

Mr Keith Raffan (Mid Scotland and Fife) (LD): Mr Harper Gow has already partly answered this question, but I wish to put it to Mr Owens. You raised the issue of increased accountancy fees, and Mr Harper Gow basically said that the number of contractors who appealed was negligible. Is it correct to say that a relatively small amount was involved?

Mr Owens: Sorry, could you—

Mr Raffan: You raised a point about increased accountancy fees as a result of the delays and so on, and individual pharmacy contractors were involved in that. Mr Harper Gow said that very few of them actually raised that with the Common Services Agency as an issue, presumably asking for help with those fees; therefore, the amount involved must have been negligible. You raised the matter and made it sound like a major thing, while Mr Harper Gow basically indicated that it was not.

Mr Owens: I know of one contractor who, unfortunately, had to pay an additional £800 to have his books finalised for the past financial year. Personally, I have spent considerable time trying to put down on paper exactly what happened to allow my accountant to make sense of the audit

trail.

Mr Raffan: Therefore, increased accountancy fees were quite a burden to some individual contractors.

Mr Owens: Yes.

Mr Raffan: You also said that some contractors had to go back to the banks, presumably to negotiate loans. I assume that such loans would have involved interest payments. Did those payments also amount to considerable sums?

Mr Owens: I cannot answer that. I am sure that my support staff who are here today would be able to give me that information, as a number of contractors contacted the offices of SPGC to seek advice.

14:45

The Convener: The nature and volume of primary care payments make it impractical for them to be authorised in advance. Given that there are 60 million transactions with a value of £1.3 billion, it is essential that a robust and consistent verification system should be in place. Margaret Jamieson will ask questions about the delay in implementing robust and consistent payment verification arrangements.

Margaret Jamieson (Kilmarnock and Loudoun) (Lab): I have some questions for Mr Harper Gow. Last year, the committee considered the issue and recommended that payment verification arrangements should be developed as a matter of urgency. Will Mr Harper Gow update the committee on that? Why was no formal agreement in place in 2000-01 between the CSA and primary care trusts detailing responsibility for payment verification?

Mr Harper Gow: I am happy to try to answer those questions. First, I will deal with the formal agreement between the CSA practitioner services division and the primary care trusts and island health boards. We were all on a learning curve with the new system. You will recall that in April 1999, when the CSA became responsible for primary care administration, the primary care trusts were formed as part of trust reconfiguration. We were therefore very much on a learning curve.

The emphasis was on pulling together a payment verification protocol that forms a central part of the formal agreement between the CSA and the trusts—we call that a partnership agreement. The payment verification protocol was completed only towards the end of 2000. It was approved in parallel by the health department and the NHS in early 2001. It was not until the summer of 2001 that the audit community agreed that, as far as it could tell, the protocol met its requirements.

Until that happened, it was not felt that we could put together a formal agreement between the agency and the primary care trusts and island health boards. We have now done so and 16 agreements out of 17 are in place. The remaining agreement requires some minor adjustments.

Margaret Jamieson: To which area does the outstanding agreement relate?

Mr Harper Gow: The Western Isles.

You asked what we have done about payment verification. Payment verification consists of pre-payment checks that are made by the computer systems and manually by CSA staff. Among other things, post-payment checks involve analysis of data output; analysis of the various management information reports that come out of the systems; various statistical analyses identifying, for example, outliers; calling in records; and practice visits.

Under the new protocol, four levels of checks are made. Level 1 checks are 100 per cent pre-payment checks, which are largely automatic checks made by the computer systems. Level 2 checks are sample pre-payment checks that are partly targeted and partly random. Level 3 is an in-depth review of the output from the payment and management information systems. Level 4 involves the examination of patient records and, in cases involving ophthalmic and dental practices, of the patients. As I mentioned, targeted as well as random practice visits can be included.

Payment verification has been in place for several years for all four contractor groups. It became the agency's responsibility in 1999, when we took over primary care administration. At that time, the CSA carried out quite a lot of checking in respect of pharmacists and dental practices, for which we had previously been responsible, whereas health boards had carried out payment verification tasks for ophthalmic and general medical practice. In general, we continued to do in our three new offices what had previously been done. We merged 15 areas into three, so it is obvious that some inconsistencies would arise. Practice visits in respect of the general medical service—the general practitioners—continued in the Lothian health board area, but discontinued in Fife and Tayside, or were pursued only at a lower level than previously. Those were the only areas that did practice visits in respect of the general medical service.

Overall, we believe that the level of activity from 1999 onwards represents an increase in payment verification throughout the service. In 2000-01—the year under review—developments continued. In particular, we set up the fraud investigation unit in July 2000 to address patient and contractor fraud as a further step in developing payment

verification. The fraud investigation unit draws on payment verification output to target investigations. As I mentioned, the first payment verification protocol was drawn up by the service and agreed by all the parties, although that process took until August 2001.

One or two things still have to be done. There is still a need to revise some regulations that govern such activity. As I mentioned, the partnership agreements have been in place since the end of calendar year 2001. Routine reporting started at the beginning of 2001-02—the year subsequent to that which is the subject of the review. It covers all 17 primary care trusts and island health boards. We have recruited a payment verification team that includes 17 and a half whole-time equivalent members of staff, who cover all four contractor groups. We still have to fill three vacancies.

Patient-exemption checking is an issue—it is not as complete as we had planned. It has not been possible to reach agreement with other Government agencies for access to some data that would serve to confirm individuals' exemption status.

If the committee wishes, I can talk about the extent of payment verification as outlined in the payment verification protocol for each of the four contractor groups.

The Convener: We will deal with that shortly. First, Keith Raffan has a question.

Mr Raffan: Mr Harper Gow, you mentioned that visits in Fife and Tayside were discontinued. Why? Will you elaborate on that?

Mr Harper Gow: You may recall discussions that we had about a year ago. At one time, there was a considerable difference of opinion between various parties as to the value of such visits, particularly if they were made on a random as opposed to a targeted basis. If any contractor attracted attention through, for example, outlier analysis, we would follow that up, but not necessarily with a practice visit. Transferring records into our offices, for example, is obviously a more efficient way of dealing with such issues or carrying out an investigation. From our point of view, we would not have to send staff around the countryside. Equally, there would not be a lot of foreign bodies such as auditors tramping around the various practices asking questions when the staff were trying to do their business.

We carried out as much payment verification as we were able to do. We had problems with the regulations and the resources, but it was not as if no payment verification was carried out at that level.

Mr Raffan: I do not find that satisfactory. I would like to ask Mr Brechin and Mr Ranzetta about that, but I think that we will have an opportunity to do that in a few minutes' time.

The Convener: Mr Harper Gow, you mentioned that you set up a fraud investigation unit. That sounds impressive, but what exactly is it? What staff does it have? Have you any early results? What triggers an investigation and how does the unit investigate?

Mr Harper Gow: The unit was set up as a separate unit within the practitioner services division in summer 2000 as part of the development of primary care administration. In other words, it was part of the original project to centralise primary care administration in the agency.

I do not have the staff numbers to hand. I think that there are between 10 and 12 members of staff in the unit. It works with other Government and NHS fraud units and carries out sampling to try to identify outliers. It takes information from our existing databases and follows up other leads that it gets, which can come from a variety of agencies and from members of the general public.

The Convener: You can confirm the number of staff later. How many investigations has the unit undertaken?

Mr Harper Gow: I cannot answer that, as I do not have that information. A report was produced for the unit's first year in summer 2001 and was, I think, made available to MSPs. It was certainly published. It is my understanding that it was made available to MSPs.

The Convener: It would be handy for the committee to have a copy.

Margaret Jamieson: We dealt last year with the transfer of staff from all the health boards and other aspects of the setting-up of the new authority, but there has been a considerable settling-down period and people are now much more familiar with the one-view approach rather than 15 individual views. However, there seems to be a lack of information at a local level about how members of the public can make complaints and about the service input into that. Individual trusts will obviously still have views on the prescribing nature of certain general practices and individual GPs. How does all that fit together? I have yet to see any evidence of cases having been instigated since 2000 whereas we previously saw court cases mentioned on occasion in reports to the individual professional bodies, such as the case of the orthodontist who covered the west of Scotland in which a number of health board areas were involved.

Mr Harper Gow: I am sorry. I do not have details of the level of activity of the fraud investigation unit, but it has a number of on-going

cases. I am pretty certain that its activity has led to some disciplinary actions, if not prosecutions. Discipline is a matter for the primary care trusts. The last time that I saw figures, there were 20 or 30 cases under investigation, some of which will have been closed.

The report to which I referred a few minutes ago has only certain details of cases. You understand the reason for that. We can update the committee, if you would like, on the position vis-à-vis the fraud investigations that the unit carries out.

You asked about complaints by members of the public. Complaints about primary care services, whether they are directed to the primary care trusts or to us, will be dealt with through the NHS complaints procedure, which, as you know, is under review. The complaints mechanisms that we have in the CSA are used from time to time. The board secretary, who is sitting behind me, acts as our complaints officer as well as doing all her other work.

15:00

Margaret Jamieson: Paragraph 18 of the Auditor General's report indicates that the payment verification protocol that was recently agreed by the CSA and primary care trusts proposes targeted practice visits and a small random sample of visits. You alluded to that when you talked about the four levels of checks. Does that happen across the board? Is every health board area treated the same or do you make more sample checks or targeted checks in certain health board areas? Do you have a service level agreement with each of the primary care trusts?

Mr Harper Gow: We call it a partnership agreement but it is the same as a service level agreement or a service level contract.

The targeted practice visits will be based on evidence or information that warrants further investigation. On the random practice visits, the PV protocol calls for a sample of 1 per cent to be taken. That is quite impractical, as it is such a small number, but we have aimed to ensure that there is at least one random practice visit in each of the 17 areas that are covered by the primary care trusts and the island health boards. This year—2001-02—the practitioner services division regional offices in Edinburgh, Glasgow and Aberdeen are conducting practice visits. All 17 areas will be covered by those visits apart from Orkney, which, it has been agreed, will conduct its own practice visit.

You asked about consistency. The Aberdeen and Glasgow offices, which previously did not operate practice visits in relation to general medical services, operate according to the new protocol. The Edinburgh office is completing its three-year programme, which it inherited from the various health boards. As part of that three-year programme, we have extended the coverage in the five areas that are covered by Edinburgh, which extend from the Borders to Fife and the Forth valley. In three of those areas, there is a high level of coverage of over 50 per cent. In the areas covered by Glasgow and Aberdeen, this is the first year that the system is being applied. A number of practice visits have been completed and further ones will have been completed by 31 March, the end of the financial year.

Margaret Jamieson: Could you supply us with the specific number of visits that will have taken place across Scotland this financial year?

Mr Harper Gow: The total number planned for this financial year—which has around four weeks left to run—is 80. That covers 16 of the 17 areas, the exception being Orkney, which is conducting its own random visit.

Margaret Jamieson: How many contractors does that cover?

Mr Harper Gow: I cannot answer that question, because there will be different numbers of individual practitioners in each practice. Some will be single-doctor practices and some will be multi-doctor practices. I am sorry that I do not have the information.

Margaret Jamieson: It would be helpful if you could provide it.

Mr Davidson: What triggers an investigation into a practitioner, regardless of specialty? What is the area of greatest concern? Is it patient fraud with prescription claims, contractor fraud, mismanagement or carelessness?

Mr Harper Gow: In general medical services, the area in which practice visits take place, the area of greatest concern is contractor fraud, not patient fraud, although there could be collusion in some cases. I have heard of instances of collusion, with payments being made for night visits that did not take place, for example, but the aim of our investigation is to uncover contractor fraud.

The protocol covers about 10 areas for which payment is made. Each of those areas is reviewed by the appropriate payment verification protocol, because different payments attract different types of verification. I am not aware of any specific area of concern that has triggered targeted practice visits; I would have to inquire about that.

Mr Davidson: Are you thinking of examining other health service contractors in the same way?

Mr Harper Gow: Payment verification covers all four contractor streams, but practice visits are currently permitted only for general medical

services. We do not visit ophthalmic or dental practices, for example, but we do meet patients. On occasion, we invite dental patients to our centre in Glasgow to have work that has been done—or, pre-payment, the need for work to be done—inspected. We also now have an ophthalmic adviser who does the same for ophthalmic services.

Mr Raffan: When you talked about discontinuation of services in Fife and Tayside, were you referring to 2000-01?

Mr Harper Gow: The two areas had their own programmes until the end of 1998-99. We became responsible in 1999-2000 and 2000-01, and we did not do practice visits during those two years.

Mr Raffan: How many visits have there been in those areas in the current financial year? Did you say that there had been 80 overall in Scotland?

Mr Harper Gow: Yes. I think that, in Fife—

Mr Raffan: You could let us have the figures later. I do not want to delay proceedings now.

Mr Harper Gow: I have them in my office; I shall send them to you.

Mr Raffan: What you said earlier worries me slightly. You said, "What's the point in tramping across the countryside and disturbing practitioners at work?" There are obviously non-surgery hours when you could gain access to a surgery and get a transfer of the records. Is that right?

Mr Harper Gow: Yes.

Mr Raffan: How reliable is that? If somebody is on the spot to get records and they want additional information, they can ask for it there and then. Getting that information transferred could take a day or two. Who knows how reliable that information would be or what might happen to it? Somebody who is on the spot can presumably undertake a speedier and more reliable investigation.

Mr Harper Gow: For payment verification, where one is looking to confirm one's understanding of something, investigation in the office is probably more effective, but we could spend a long time debating that point. There will certainly be occasions when it is necessary to do an investigation on a contractor's premises. I am making a distinction between payment verification and fraud investigation. In fraud investigations, we definitely attempt to arrive at about 5.30 pm on a Friday evening and do what we have to do by 9 o'clock on the Monday morning, so that the business can open again with minimum disruption.

I have some more information about visits. By the end of 2001-02, there will have been seven visits to Fife, five visits to West Lothian, and 18 visits to the rest of Lothian.

Margaret Jamieson: After the protocol agreement that you have reached has cleared the various hurdles and the strict guidance of the audit community—you referred to "foreign bodies"—has been met, how will you ensure that the protocol is working and that it meets various criteria?

Mr Harper Gow: The protocol is subject to monthly monitoring and reporting. However, we are not as far ahead as we hoped we would be when we drew it up about 12 months ago. It took longer than expected for all the parties to agree to the protocol and for us to recruit the staff. It is fair to say that we took our eye off the ball with pharmacy because we needed to catch up. With the benefit of hindsight, I think that we did not pay enough attention to payment verification in that particular stream. Although we are attempting to remedy the situation, it is unlikely that we will achieve all that we had hoped to achieve by 31 March.

Margaret Jamieson: Are you saying that the protocol is not working?

Mr Harper Gow: The protocol was to be implemented progressively. I have already mentioned that some regulations have to be changed, which is a matter for the Scottish Executive health department. I think that someone earlier confused the Common Services Agency with the health department in that respect; the CSA does not change regulations. There is a progressive plan to implement the full payment verification protocol over a particular period; however, we are further behind with that than we should be.

Margaret Jamieson: What steps are you taking to speed up the process? As the convener indicated, we are talking about £1.3 billion of public funds.

Mr Harper Gow: As I have mentioned, apart from three outstanding vacancies, our team is now in place. We are introducing new systems. For example, we have had much discussion this afternoon about the data capture validation and pricing system for pharmacy. We are also introducing new systems for ophthalmics, and are enhancing the management information and dental accounting system, or MIDAS. However, all those steps take time. We have a programme—which I do not have in front of me—to roll out the full PV protocol over a particular period.

Margaret Jamieson: It would be interesting if you could provide us with the programme, as it is part and parcel of our overview.

The Convener: When will the PV protocol be fully implemented?

Mr Harper Gow: I would prefer to come back to the committee with a firm date. I do not have that information in mind at the moment.

Mr Davidson: A representative of one of the contracting groups is present this afternoon. Perhaps he would care to comment on the consultations on and the roll-out of the protocol, and highlight any suggestions that his group has made about the protocol.

Mr Owens: I am not sure that I can comment on that matter at this stage. We have no information on the protocol. We have not discussed with the PSD or the department how it will roll out.

Mr Davidson: I presume from Mr Harper Gow's comments that you will look out for and comment on such a proposal if it is rolled out in pharmacy, for example.

Mr Owens: We have not considered the matter, so it would be inappropriate for me to comment.

Mr Davidson: Fair enough.

The Convener: You might wish to make a written submission when you have had time to think about the question.

I presume that all the appropriate bodies are being consulted while the plan is being rolled out.

15:15

Mr Harper Gow: The primary care trusts and the department have been consulted extensively. I understand that discussions were held with contractor groups. I said that pharmacy was further behind, as a result of our concentrating on the catch-up. If it is said that no discussions have been held with the Scottish Pharmaceutical General Council, I accept that. I am certain that discussions are intended to be held.

At present, payment verification in pharmacy is the long-standing pre-payment checking and information analysis that happen as part of our routine work systems. For example, as I understand it, we cannot make practice visits to pharmacies for payment verification, although we can do that for clinical purposes.

Mr Owens: Perhaps I can assist. We have had informal talks with Neil Billings of the fraud investigation unit, but there has been no discussion, formal or otherwise, between the department or the CSA and the Scottish Pharmaceutical General Council.

The Convener: It would be useful for the committee to have a note of what consultation took place and when. I ask Mr Harper Gow or his successor to supply that information to us.

Mr Raffan: Perhaps Mr Brechin can answer my question. Mr Harper Gow said that primary care trusts had been consulted extensively. Did Fife Primary Care NHS Trust, for example, consult local pharmacists or other local contractor groups?

Mr Brechin: The short answer is that I do not know. Trusts were consulted Scotland-wide and negotiated a partnership agreement that gives us confidence about the sampling and checking levels. I have just looked behind me for a smile of help from my colleagues, but I saw none. Discussions may well have been held with my local professional committees. I do not know.

Mr Raffan: Perhaps you could let us know.

You are accountable for the primary care trust's expenditure. How concerned have you been about the rate of progress—if that is the appropriate term—in introducing sound verification arrangements?

Mr Brechin: I would prefer to rephrase that question to include the words "better codification and more thorough arrangements". Arrangements were in place before responsibility was transferred to the CSA. We have worked with our colleagues to improve those arrangements. As Mr Harper Gow said, in Fife we said fairly early on that we wanted post-verification visits to GPs. Other parts of Scotland were not working in the same way. However, such visits are only part of the spectrum of visits to contractors and of other changes that have improved the system. One change in the past couple of years is the requirement on contractors to check claims for exemption. That has made a significant difference.

To pick up on an earlier question, some work has come through from the fraud investigation unit. I can think of two significant cases that are being examined in Fife—one closed recently and the other is continuing. Fraud liaison officers meet regularly with the central fraud unit so that the local systems are plugged in.

The short answer to your question is yes. We were in discussion with the practitioner services division about delivering the gamut of payment verification. It is a concern to us. Although I said earlier that the over-estimate is relatively small, it is still a lot of money and we still require to ensure that public money is properly spent. We were in discussion with the CSA. Indeed, the fact that we took the issue so seriously is demonstrated by the time that it took to sign off what is now a detailed verification agreement, which runs to about 50 pages.

Mr Raffan: Do you mean the protocol?

Mr Brechin: Yes. That determines the basis of the checking. We do take the issue seriously.

Mr Raffan: Are you happy with the protocol?

Mr Brechin: I do not think that one is ever happy but it is a lot better than it was. Yes, I am confident that it enables me to discharge my responsibilities to the committee and as the accountable officer.

Mr Raffan: What would it take to make you happier, or are you just being your normal gloomy self?

Mr Brechin: Do I have to answer that question? I would like to have some experience of the new system before I say that I am satisfied that we should stop there.

Mr Raffan: Is there an agreement to review the protocol after a period of time?

Mr Brechin: We should automatically do a review before we sign the next year's version. On the other hand, we are getting much better. A system called PRIME—practice information management evaluator—considers a raft of items of service or recorded claims and relates them to the per capita population. From that, we can pick outliers, which enables us to target our activity using fairly sophisticated statistical sampling as well as the 100 per cent checks that Mr Harper Gow talked about. As we get better at that, I am becoming happier.

Mr Raffan: Are you happy with the number of practice visits?

Mr Brechin: With the help of our colleagues in the PSD, we completed the Fife programme of 100 per cent visits to general medical services by March 2001. We had done about two thirds of the programme before 1999. We completed the remaining third and have done just under 10 visits under the new system.

I accept that statistical sampling helps to reduce the need for random visits, but there is still benefit to be gained from random visits.

Mr Raffan: I turn now to Mr Ranzetta. In the same way as most health boards, Fife Health Board's accounts for the year 2000-01 were qualified because of the absence of a comprehensive framework for payment verification. Are you now satisfied with the protocol and what has been achieved?

Mr Tony Ranzetta (Fife NHS Board): I find myself in the same situation as Mr Brechin. I agree that significant strides have been taken in the past 12 months. In 2000-01, 25 practice visits were conducted. A further nine targeted visits have been conducted in 2001-02. That satisfies me in a way in which I was not satisfied previously.

I want to evaluate—as we all do—the benefits of a targeted approach over an approach where all practices are visited over a three-year period. When the 1997 guidance came out in Fife, there were good reasons for introducing a three-year programme. We want to ensure that the same standards of practice are achieved with the targeted approach.

Mr Raffan: Since the creation of unified health boards following the health plan, accountability lies more with the health board and you are more directly accountable for primary care payments. Do you believe that that will expose you to greater risk?

Mr Ranzetta: Accountability for that area was only devolved to the primary care trust. I have never lost that accountability.

Mr Raffan: Arguably, it is greater now.

Mr Ranzetta: It would be better to say that it is more clearly stated.

Mr Raffan: Until you disappear to Suffolk.

Mr Ranzetta: Do I think that we are more exposed? In Fife, we felt exposed in 2000-01, because we were working together to ensure that our collective financial performance came up to the standards that the committee expected. We did not apportion those responsibilities to particular organisations, as we felt that it was in the interests of the NHS to work collectively. The creation of a unified health board has merely reinforced that message.

I feel as exposed now as I did in 2000-01. There is a level of risk. The protocol that is now in place reduces the risk. The risk was greater in 1999-2000 when there were no practice visits in Fife. I reserve the right to evaluate the success of the protocol after it has run for some years, to see whether it achieves the standards of verification that were achieved in Fife before responsibility transferred to the CSA.

The Convener: Thank you. That completes our evidence taking. Would any of the witnesses care to make a final statement?

Mr Ranzetta: I would like to make a statement about the computerised information that we have. One of the problems that we encounter in the NHS is the timeliness of the management information that we receive. I do not believe that we can speed up the information coming back from the existing system, because the system was designed, first and foremost, to remunerate people on the basis of the amount of prescriptions. We need to consider seriously a parallel system that provides decent management information in a timely fashion for those who administer the budgets, so that they can see whether there are differences in prescribing trends within weeks rather than months, as is the case now. The system carries a significant risk, so we need to consider the development of new systems that divorce remuneration from management information.

Mr Davidson: Are you saying that it is a far greater priority for the boards and trusts to consider clinical effectiveness and patient risk than it is to consider the financial risks? I appreciate that we are talking today about the financial aspects, but that seemed to be your drift.

Mr Ranzetta: That was not my intention. I meant to say that good management information also needs to be timely. If there is a time lag in providing the information on prescribing costs, it prevents the link between management action and its consequences from being described accurately. A system that describes expenditure on the basis of prescriptions, using a system of payment verification, is extraordinarily helpful in providing reliable processes for auditing the payments made, but it does not necessarily meet the standard of timeliness of information that management needs.

Mr Davidson: So, you are looking to the management structure to help prescribing advisers, for example, in using practice formulae.

Mr Ranzetta: Absolutely.

Mr Davidson: Do you feel that the department is giving that work enough support?

Mr Ranzetta: The department is not considering the issue at the moment. It is looking at the verification of payments and using that system to provide management information. However, those elements sit very uncomfortably together.

The Convener: I thank all our witnesses and their staff for their evidence, which will help the committee.

We should now move on to agenda item 3, but we are slightly ahead of schedule. I propose that, rather than suspend the committee while we await the minister, the committee should move to agenda item 4, which will be taken in private. Item 4 is consideration of the evidence that we have received so far, and it is our practice to consider such evidence in private before we produce our public report. Are we agreed to move to item 4?

Members *indicated agreement*.

15:29

Meeting continued in private.

15:38

Meeting suspended.

15:52

Meeting continued in public.

Subordinate Legislation

Public Finance and Accountability (Scotland) Act 2000 (Consequential Modifications) Order 2002

The Convener: I welcome the Deputy Minister for Finance and Public Services, Mr Peter Peacock, and invite him to speak to and move motion S1M-2736.

The Deputy Minister for Finance and Public Services (Peter Peacock): I hope that members will agree that the order is a straightforward technical matter of tidying up existing arrangements, but only time will tell whether that is the case.

As members will be aware, the Public Finance and Accountability (Scotland) Act 2000 modified legislation that set up statutory bodies such as some non-departmental public bodies and health service bodies so that their accounts would be audited by the Auditor General for Scotland. Some bodies were inadvertently omitted from the modifications, but section 26 of the 2000 act allows ministers to amend by order enactments that relate to part 2 of the 2000 act.

We are making the present order to tidy up provisions and arrangements for the auditing of certain accounts, in particular the accounts of the Scottish Tourist Board and accounts that are prepared by ministers in relation to the Erskine Bridge Tolls Act 1968 and non-domestic rating, which the Scotland Act 1998 states must be audited by the Auditor General for Scotland. The existing provisions must be tidied up so that they conform to sections 21 and 22 of the 2000 act. The order's proposed modifications would do that.

The Scottish Hospital Endowments Research Trust currently employs its own auditors. The audit provisions of similar authorised bodies were modified by the 2000 act, so that instead of appointing their own auditors, their accounts must be sent by ministers to be audited by the Auditor General for Scotland. The order's proposed modifications would allow that to be done for the trust's accounts.

I move,

That the Audit Committee, in consideration of the draft Public Finance and Accountability (Scotland) Act 2000 (Consequential Modifications) Order 2002, recommends that the order be approved.

The Convener: The order is a tidying-up measure that creates a straightforward duty to report accounts to Audit Scotland, and hence open

them to public scrutiny and accountability. As it seems that members have no questions, I will put the question.

The question is, that motion S1M-2736, in the name of Andy Kerr, be agreed to. All those in favour say aye, those to the contrary say no.

Motion agreed to.

The Convener: The ayes have it.

I remind members that the next meeting will be on Tuesday 19 March at 2 pm in committee room 1.

Meeting closed at 15:55.

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