AUDIT COMMITTEE

Tuesday 30 September 2003
(*Morning*)

Session 2

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AUDIT COMMITTEE
5th Meeting 2003, Session 2

CONVENER

*Mr Brian Monteith (Mid Scotland and Fife) (Con)

DEPUTY CONVENER

*Mr Kenny MacAskill (Lothians) (SNP)

COMMITTEE MEMBERS

*Rhona Brankin (Midlothian) (Lab)
*Susan Deacon (Edinburgh East and Musselburgh) (Lab)
Robin Harper (Lothians) (Green)
*Margaret Jamieson (Kilmarnock and Loudoun) (Lab)
*George Lyon (Argyll and Bute) (LD)

COMMITTEE SUBSTITUTES

Chris Ballance (South of Scotland) (Green)
Mr Ted Brocklebank (Mid Scotland and Fife) (Con)
Marlyn Glen (North East Scotland) (Lab)
Mr Andrew Welsh (Angus) (SNP)

*attended

THE FOLLOWING ALSO ATTENDED:

Mr Robert Black (Auditor General for Scotland)
Caroline Gardner (Audit Scotland)
Barbara Hurst (Audit Scotland)
John Simmons (Audit Scotland)

THE FOLLOWING GAVE EVIDENCE:

Mr Trevor Jones (Scottish Executive Health Department)
Mr Bill Scott (Scottish Executive Health Department)
Dr Hamish Wilson (Scottish Executive Health Department)

CLERK TO THE COMMITTEE

Shelagh McKinlay

SENIOR ASSISTANT CLERK

Joanna Hardy

LOCATION

Committee Room 2

Scottish Parliament

Audit Committee

Tuesday 30 September 2003

(*Morning*)

[THE CONVENER *opened the meeting in private at 09:49*]

10:13

Meeting continued in public.

The Convener (Mr Brian Monteith): I welcome members of the public and press to the fifth meeting of the Audit Committee in this session of Parliament. I remind everyone, including committee members and guests, to ensure that mobile phones and pagers are turned off so as not to disrupt the proceedings or our delicate public address system. No apologies have been received.

Items in Private

10:15

The Convener: Members will be delighted to discover that the next agenda item is to consider whether to take agenda items 6 to 9 in private.

For the record, I will quickly run through the purpose of taking the items in private. Item 6 is to discuss the oral evidence taken on general practitioner prescribing, to help us to put together a report. Item 7 is to consider the committee's approach to the "Hospital cleaning" report. Item 8 is to consider arrangements for, and the approach to, the committee's forthcoming inquiry on the issues raised in "Moving to Mainstream: The inclusion of pupils with special educational needs in mainstream schools". Item 9 is to consider arrangements for, and the approach to, the committee's inquiry relating to the Auditor General for Scotland's report "Scottish Further Education Funding Council: Performance management of the further education sector in Scotland".

The items involve planning ahead and consideration of what our reports might be, where they might go and which witnesses we might require. Do members agree to take agenda items 6 to 9 in private?

Members *indicated agreement*.

"Hospital cleaning"

10:17

The Convener: Item 3 is on the Auditor General's report "Hospital cleaning". I invite the Auditor General and the relevant members of his team to give a brief report.

Mr Robert Black (Auditor General for Scotland): In April 2000, I published a baseline report that made a number of recommendations that were aimed at improving the quality of hospital cleaning. At that time, national health service trusts were expected to take action on those recommendations. I asked Audit Scotland, with the support of the committee, to follow up and report on progress. The report that we are discussing is a follow-up progress report. Trusts are named in the report because they have had the opportunity to make improvements during the past couple of years. The report was published in January and, as the convener will be aware, was discussed by the Audit Committee at a meeting in February. It was decided not to take evidence then because of the pressure of other business.

The report describes our findings on hospital cleaning. I do not intend to go into them in detail, but I am happy to answer questions or to give the committee a fuller briefing. In general, we found that half of hospitals had very good or acceptable levels of cleanliness in all areas reviewed, but that there was a clear need for improvement in almost 20 per cent of hospitals, with the remainder having shortfalls in some areas. The report identifies some of the issues that seem to make it more difficult for hospitals to achieve acceptable levels of cleanliness.

My only other introductory point is that, since the report was published in January, action has been taken nationally. First, the Scottish Executive Health Department wrote to all health boards and trusts asking them to implement the report's recommendations. Secondly, the hospital-acquired infections task force, which is chaired by the chief medical officer, has recently published two key documents for consultation. The first is a code of practice on infection control and the second contains technical requirements for processes to be used in the NHS specifications for cleaning services. Finally, NHS Quality Improvement Scotland is due to undertake a round of reviews against the cleaning standards, with reports due for publication in 2004. We also know that a number of trusts have put in place improvement plans for cleaning and that, where local follow-up audits have taken place, improvements have been found. As ever, there has been a moving picture since the report was published in January.

George Lyon (Argyll and Bute) (LD): The report's conclusions state:

"There is no clear association between the level of cleanliness and any one of the factors investigated."

The report lists a number of factors that make it more difficult for hospitals to achieve high standards of cleanliness. To turn the question round, what are the key factors that result in hospitals having a successful cleaning regime? That seems to me the fundamental issue.

Mr Black: That is a good question. I ask Caroline Gardner or Barbara Hurst to answer it.

Caroline Gardner (Audit Scotland): I will have the first go. In our findings, no single factor is associated with acceptable levels of cleanliness, but trusts that did not have problems with any of the four points that are set out in the briefing paper were much more likely to be able to assure cleanliness for patients who use their hospitals than trusts that had something wrong in one or more of those areas.

We considered all the factors that one might expect, such as whether the cleaning service was provided by an in-house team or an external contractor, the specifications used and whether those specifications focused on frequency of cleaning or on outputs. We found that not having problems with those four points was the best predictor of acceptable cleanliness, but that, in one or two hospitals, things were going wrong in spite of that. The matter is complex, but those four points are the most important drivers of acceptable levels of cleanliness in hospitals.

George Lyon: The report states:

"A number of hospitals, such as Yorkhill, Queen Margaret … Royal Edinburgh and Belford (Fort William) achieved generally high levels of cleanliness while having high levels of sickness absence and staff turnover."

How did those hospitals manage that?

Caroline Gardner: They monitored regularly and were prepared to be flexible about the way in which they used available staff, rather than sticking to the original plans.

George Lyon: So the fundamental difference came down to management of the available resources.

Caroline Gardner: Clearly, it is harder to achieve high levels of cleanliness if sufficient resources to deliver cleaning are not routinely in place.

George Lyon: I understand that.

Caroline Gardner: We found that hospitals that were able to overcome high levels of sickness absence and staff turnover had managed the situation better than the ones that could not overcome those high levels.

George Lyon: So the key was the quality of the management.

Caroline Gardner: At the end of the day, that made the real difference.

George Lyon: I assume that the reverse was true for hospitals that appeared to have no particular difficulties with staffing inputs and turnover but which failed to achieve acceptable levels of cleanliness, such as Bonnybridge hospital, Falkirk and district royal infirmary, Inverclyde royal hospital and Whyteman's Brae hospital. Was the management extremely poor in those cases?

Caroline Gardner: It is not fair to make such a sweeping generalisation. The report also mentions that, in some places, problems with the fabric of buildings make it much harder to keep them up to the acceptable level of cleanliness.

George Lyon: Is that because the buildings are old?

Caroline Gardner: Some are old; others have out-of-reach areas. One hospital has difficult-to-access stairwells and windows that are hard for cleaning staff to reach.

George Lyon: The report highlights rates of absence and staff turnover as key points. How do those rates compare with rates in other sectors of business? Are they higher or lower than the norm? Does the NHS have particular problems?

Caroline Gardner: Barbara Hurst has information on that.

Barbara Hurst (Audit Scotland): We have done similar work in other sectors—a comparator might be home care workers in the local government sector. The rates are comparable—we found high turnover and sickness absence rates. Part of the reason for that might be the nature of the job.

George Lyon: Is that true regardless of whether private contractors or directly employed in-house staff do the work? Was there any differentiation?

John Simmons (Audit Scotland): The main factor affecting turnover appeared to be the availability of other jobs in the area. As one would expect, where there was competition from private cleaning jobs or from companies such as Tesco, the turnover rate tended to be much higher.

Margaret Jamieson (Kilmarnock and Loudoun) (Lab): The response that we have received from the Executive—Trevor Jones's letter dated 20 February and John Aldridge's letter dated 28 January—indicates that the Executive is ensuring that the trusts and other parts of the NHS system throughout Scotland will be required to report on cleaning in the tick-box part of their performance assessment framework. Is Audit

Scotland happy that that is the way in which the centre will undertake continuous measurement? Are you satisfied that trusts are fully aware of their obligations under the two letters? Page 9 of the report, under the heading "staff turnover and absence", says:

"many trusts had still to put in place a programme to reduce sickness absence to the national target of 3%".

That national target has existed for some time and I assume that there is a box for it in the performance assessment framework, but nothing appears to have been done on that. If we compare performance on the target that has existed for some time with what we are now asking trusts to do, how much confidence do you have that we will move the matter forward?

Mr Black: The short answer is that we have not audited since the publication of the report and we therefore do not have objective evidence with which to give you a full answer to that question. However, as I indicated in my preliminary remarks, the Health Department has been active in putting in place explicit standards and requiring NHS bodies to apply those standards through action planning.

Barbara Hurst: I support what the Auditor General has just said. The most powerful part of the report was the peer review—the actual consideration of the cleanliness of hospitals. We note that the hospital-acquired infections task force has picked that work up and wants to develop it. We support that, because, although all the management processes can be examined, clean hospitals are what we all really want. The power of work such as the report lies in providing an on-going way of checking cleanliness.

Margaret Jamieson: I come from an area in which all the hospitals are in the "very good" category—perhaps I should declare an interest. I know how much staff involvement and how much finance went into achieving that, including—if we are considering the situation as a whole—finance invested in the fabric of the buildings. The other trusts face the same pressures as those in Ayrshire and Arran, but the trusts in Ayrshire and Arran have managed to meet the objectives while others have not. How can we share their good practice? It would be interesting for me—because I have been away from the matter for too long—if you would identify what percentage of the contracts for hospitals in the poor category are external contracts. That would assist us.

Barbara Hurst: We considered the correlation between the nature of the contract and the level of cleanliness and did not find any statistical relationship between the two. Nevertheless, we found that a large number of external contractors were at the poorer end, although some were at the good end. The picture was not clear. We did not push the nature of the contract as a major factor in the report, although we said that, if monitoring of external contracts is not good and good clauses are not built into those contracts, there is quite a big risk factor. We were careful to highlight that as an issue in the report.

Rhona Brankin (Midlothian) (Lab): I am interested in the point that Margaret Jamieson made. Barbara Hurst returned to the difficulty of ensuring quality across the range of service providers. Do you consider that to be an issue that the health bodies need to address?

10:30

Barbara Hurst: When we did the review, which is a little while ago now, we were aware that a number of trusts were bringing their services back in house, as they had identified some issues with the external contracts. The balance between external and in-house contracts will be quite different now. Nevertheless, peer review—checking the cleanliness—can be done irrespective of the nature of the contract. We need to keep up the major push on that.

Rhona Brankin: That is what I was going to explore. The key is ensuring that adequate systems exist for quality control and monitoring, regardless of who the provider is.

Barbara Hurst: Yes.

George Lyon: The table on page 19 of the report shows those trusts that managed to meet the cleaning, supervision and monitoring standards, those that achieved less than planned and those that achieved more than planned. Is the amount that each trust spent linked to those figures? Did you make a comparison to find out whether finance, absence rates or management was the driver? Could you give us some idea why the variations occurred and what the key drivers that made the difference were?

John Simmons: The key driver is not finance, in that what was planned was budgeted for and therefore the money to provide the planned input was available.

George Lyon: Was the budget spent?

John Simmons: The budget would not necessarily be spent if a trust did not have the staff. When a trust does not get its full level of staff, the problem tends to be that it cannot get hold of bodies to do overtime or to fill the gap. It obviously cannot just pull somebody off the street—some training is needed. As soon as the turnover rate becomes high, a problem with achieving the planned input occurs.

George Lyon: An interesting question then arises: did you examine the output for the money spent, for example the square metreage cleaned versus the amount spent? You say that lack of staff is the fundamental problem. Full employment is probably what is behind the recruitment problem. Did you examine outputs—what was achieved given the manpower available and the money spent?

John Simmons: We started to do that, but we decided that we did not have an accurate enough measure. We could use square metreage, but the square metreage for a hospital with high ceilings is not the same as that for one without. There would be other problems if we measured old hospitals against new. Also, different floor coverings take different amounts of cleaning. Several different factors affect the amount of input that is needed. It is not just a matter of the efficiency of the cleaning operation.

Margaret Jamieson: What, then, is the point of having the figures from the information and statistics division—the blue-book costs? Those give us the square metreage costs throughout Scotland, and everybody is told to keep to the average. If those figures are made up of comparisons that are not like for like, why do we collate them? Why did you not use them in the report? I appreciate fully what you say about the fact that any two hospitals can differ in age, layout and the way in which patients use them. There is a difference, but that difference calls into question the blue-book cost.

John Simmons: I am not here to speak about the blue book. However, I point out that the intention is not that everybody should keep to the average cost in the blue book, but that they should know how they compare against the average and take account of their position. A new hospital that is easily cleaned should be better than average. A poor or old hospital that is harder to clean would expect to be worse than average. What is of interest is how much worse than average it is.

Margaret Jamieson: It is another tick box.

Susan Deacon (Edinburgh East and Musselburgh) (Lab): I will return to cleaning contracts and probe a little further into contract specifications and monitoring. Can you add anything further to give us an indication of whether problems generally exist more in respect of one or the other? In other words, in recognising the need for contract specifications that set out appropriate standards and good monitoring, did you find that there were more weaknesses in one area than in the other, or was the situation caused by a combination of weaknesses in specification and monitoring, which varied across the country?

Barbara Hurst: I hazard the answer that it was a combination. One would expect the clarity of good contract specifications to help to deliver cleaner hospitals, but that does not mean that one should not monitor against those specifications. It is an interrelationship between the two factors.

Susan Deacon: I noticed that one trust did not make its cleaning contract documents available because of commercial confidentiality. That seems a rather unusual line to take, given that only one trust did so. Did the issue come up frequently? Why was the trust able to withhold that information?

John Simmons: It depends on the wording of the contract whether the trust can withhold such information.

Susan Deacon: That response is probably relevant to my next question. Do you have, or plan to gather, information about any distinctions there might be between private finance initiative contracts and straightforward external cleaning contracts? I notice that the list of hospitals in the report mentions only one PFI hospital.

Barbara Hurst: The list contains a few PFI hospitals.

Susan Deacon: Were you able to differentiate between PFI contracts and externally provided cleaning services that are not provided as part of a PFI contract?

Barbara Hurst: I do not think that we specifically separated out cleaning services under a PFI contract. However—John Simmons will correct me if I am wrong—we found that the PFI aspect raised issues about the transparency of the contract, the amount of monitoring that was carried out against it and the penalty payments that would be charged for not achieving particular standards.

John Simmons: As there are only a few PFI hospitals, making sweeping judgments about the matter is not statistically viable. However, I should point out as an example that in one health board with two PFI hospitals, one of the hospitals did very well and the other poorly. As long as information is available and monitoring can be carried out, I do not think that PFI is necessarily a problem or that it necessarily leads to poor cleaning standards.

The Convener: That ends a fairly extensive discussion of the Auditor General's report on hospital cleaning. Members have obviously taken a keen interest in the subject. We will revisit the issue later in the meeting and decide how to take forward our response to the report. I thank the members of the Audit Scotland team for their answers to our questions.

Work Programme

10:38

The Convener: We move on to item 4, which is consideration of the committee's work programme. Members might want to have before them the accompanying paper that details the programme and tries to lay out a likely time scale for our deliberations. It also takes account of the likely publication dates of reports that Audit Scotland has compiled either by itself or with other bodies.

As members will see, our next meeting takes place on Tuesday 28 October and is followed by further meetings on 11 and 25 November. Given the amount of evidence-taking work that we will already have carried out, it is suggested that we do not take evidence on 28 October, to allow the clerks to prepare reports. I am not saying that we cannot take evidence on that date. However, if we do so, it will mean another report to compile. We are already gathering a backlog of work for the clerks, which is why the outline in the paper does not mention an evidence-taking session on 28 October.

However, we will take evidence from the Scottish Further Education Funding Council on 11 November and there will be an opportunity to hold further evidence-taking sessions on 25 November and 9 December. We can discuss the items on today's agenda later in the meeting, but it might be beneficial if I flag up to members the suggestion that, before we break for Christmas, we should take evidence on the report "Moving to Mainstream" and its financial implications for scrutinising bills.

There is also the likelihood—

George Lyon: On a point of clarification, how will we take that evidence? Are we going to carry out some investigative work on that matter?

The Convener: We will have to discuss how to undertake that work. We might decide to take oral evidence before Christmas on the financial process of passing bills, which will require holding an oral evidence-taking session with the Executive, clerks or people who handle the bill process.

The Auditor General's timetable also mentions the publication of the report on Scottish Enterprise. Depending on its exact publication date, members might also want to take evidence on that report before we break for Christmas. The fact that the work programme contains gaps does not mean that we have decided not to do anything. At each meeting, we will take up the reports that have been laid before Parliament and make decisions about them at that point. As a result, I caution members not to feel that we can fill in all the gaps immediately. Later in the meeting we will discuss the report on general practitioner prescribing and how we will approach taking evidence on hospital cleaning.

If members have no points about the work programme, I should say that as part of our intention to be open and transparent—I see smirks round the table—we will post the work programme on our website so that people can find out what we are doing. Are members agreed?

Members *indicated agreement*.

The Convener: We will keep members updated on any additions to the work programme. Some things might even be added today.

"Supporting prescribing in general practice"

10:44

The Convener: We move on to the next item, which is an oral evidence-taking session for our inquiry into the Auditor General's report "Supporting prescribing in general practice—a progress report". I welcome to the meeting Mr Trevor Jones, the head of the Health Department and chief executive of NHS Scotland; Mr Bill Scott, chief pharmaceutical officer; and Dr Hamish Wilson, head of the primary care division at the Health Department. I understand that Mr Jones is going to make an opening statement.

Mr Trevor Jones (Scottish Executive Health Department): I thank the committee for allowing me to make a few opening remarks, which will be brief. The report is very good and we welcome its findings. Its conclusions and recommendations will help us to take forward the agenda to improve prescribing practice throughout Scotland. I was particularly pleased to note that the report acknowledges the progress that the NHS has made since Audit Scotland's original report was published in 1999. That progress is down to the efforts of GPs, pharmacists and other NHS staff in driving forward the improvement agenda and I record formally my thanks to the service for that.

However, in spite of the progress that has been made, we are not complacent about the issue. We can still do more, and further improvements can be made. We spend about £800 million a year on drugs so it is critical that we make such improvements.

The report identifies helpfully a range of areas where we can make progress. It might be useful to set that in the context of our wider agenda for the NHS. Prescribing sits at the heart of a number of Executive strategies. Perhaps one of the most important recommendations relates to information management and technology. We are reviewing our strategy for IM and T and the report will be helpful in that work. It is important to ensure that IM and T developments keep pace with clinical developments. Ensuring that the clinical interface is in place is at the heart of our IM and T strategy.

Our IM and T agenda is probably more advanced in primary care than it is in the rest of the service. That is demonstrated through a range of points raised in the report but, again, we can do more. We have a robust IM and T infrastructure around general practice. Our new computer systems will default automatically to a generic equivalent when GPs receive advice on prescribing through their information technology systems. We are also moving towards computerised repeat prescribing linked to community pharmacists. The whole e-pharmacy agenda is relevant to what we are doing here.

Our pharmacy strategy, "The Right Medicine: A Strategy for Pharmaceutical Care in Scotland", sets out a clear vision of how we should relate to community pharmacists. A lot of work is going on in that area and the committee might wish to ask about it as the meeting progresses. As we implement the pharmacy strategy, we will see a better outcome for patients. We will see less opportunity for waste in drug prescribing and, critically, we will see better use of the skills of the GP and the community pharmacist. That will free up more time for the GP to spend with their patients and it is an important part of the direction that we are moving in.

Another critical part of the agenda is the new general medical services contract, which lies at the heart of the development of primary care. The quality and outcomes framework that is built into the GP contract will reward GPs for improving their prescribing practice. The contract is an important vehicle for taking forward the agenda and the committee might wish to explore it with us.

I said that we were reviewing the current IM and T strategy. A lot of work is going on in the department and the NHS to improve the clinical input to the IM and T agenda. We now have a clinical IM and T lead within the department. NHS boards are appointing directors of clinical information and the Minister for Health and Community Care is chairing a programme board to drive the IM and T agenda forward in the NHS. That is a major issue for us to take forward.

The report talks about the new PRISMS—prescribing information system for Scotland–project, which will give us better information about prescribing and will allow better engagement with GPs and community pharmacists. I hope that that is useful background to the discussion and we will answer questions as best we can.

The Convener: Thank you. That was useful. As you know, the themes that we want to pick up, which I will outline for the record, are maximising the benefits of computerisation; repeat prescribing and reducing waste; managing patients' expectations; and patient compliance. We might also wish to ask about the GP contract and its effect on prescribing.

On implementing electronic clinical communication between primary and secondary care, what might the time scale be and what are the plans for monitoring and evaluating pilots? Is there a time scale for evaluating and subsequently rolling out those pilots, if that is the wise thing to do?

Mr Jones: There is no simple answer. A vast range of clinical information systems is being developed, in secondary care in hospitals, in primary care, and between primary care and the social work sector. I cannot say when that big programme of computerisation will be complete—in fact it will never be complete, because the process of refreshing computer systems is on-going. My colleagues might wish to talk about specific projects. Specifically, Hamish Wilson might wish to describe projects around electronic communications in primary care and Bill Scott might wish to give you information about systems that are being developed with community pharmacies. As I said, there is no simple answer to the question when will we have computerised the NHS; the situation is not like that.

Dr Hamish Wilson (Scottish Executive Health Department): The ECCI—electronic clinical communications implementation—programme covers a number of clinical communications areas, such as referrals to hospitals, laboratory tests and discharge letters. Implementation is taking place through project management throughout Scotland. One specific target is to ensure that by the end of the year all GPs have access to laboratory tests. An independent evaluation of the ECCI programme is being undertaken through the University of Dundee, which will report at the end of the year. That will allow the local and national projects to take stock of what has been successful and what has not worked, and the programme to continue. As Trevor Jones said, the programme is on-going. In a sense it will never be complete, because there will always be developments that IT needs to catch up with. Do you want me to turn to the internal IT issues in primary care?

The Convener: Yes, because that might answer questions that we were going to put.

Dr Wilson: As Trevor Jones said, general medical practice has probably been fairly well developed in terms of implementing information technology. Almost every practice in Scotland has a computer system that is linked to NHSnet, which allows them to communicate with other bits of the system, whether primary care or hospitals. GPs use their computer systems in a variety of ways, but the new GMS contract, which I suspect we will return to later, will encourage practices to make even greater use of information technology in communicating with patients as well as with others in the system.

On communication between GPs, pharmacists and patients, a pilot on electronic transmission of prescriptions—ETP—has been continuing in Ayrshire and Arran since last year. We have learned the lessons from that pilot, which was about the technical infrastructure needed to allow communication between GPs and pharmacists. We have now extended that into the wider e-pharmacy programme to which Trevor Jones referred. That programme will not just consider the transmission of prescriptions, whether acute or repeat, from GPs to pharmacists via a holding store—a technical one, not a physical one—but will encompass communications between primary and secondary care and between hospital pharmacies and community pharmacies. That will be important for discharge information for patients coming out of hospital who are on specific types of medication. We are working on a range of other aspects of the e-pharmacy programme to develop ETP into something much wider. The programme will be developed and documented by around the end of the year. At that point, we will be able to give a much clearer picture of the e-pharmacy scene.

The Convener: That is helpful. Why does "The Right Medicine" suggest that the electronic transfer of prescriptions will not be in place throughout Scotland until 2005?

Mr Bill Scott (Scottish Executive Health Department): That time frame will allow the development of practice to ensure that practice is not driven by technology, but that technology underpins practice. The pharmacy supplier systems are privately purchased and we have to work with them and get agreement to develop support within the pharmacy and then links between the pharmacy and GPs and between the pharmacy and the Common Services Agency. That is complicated by changing practice at the same time as trying to introduce the new technology.

Mr Kenny MacAskill (Lothians) (SNP): I want to follow up the point that was made by Dr Wilson about community pharmacies. Given the enhanced role of community pharmacies, what access to patient information will they have? You talked about a sort of technical store. What is the actual conduit and how far will it go, from the community pharmacists' point of view?

Dr Wilson: In the current ETP pilot scheme in Ayrshire and Arran, agreement was reached between GPs and community pharmacists whereby—with the consent of patients, which is fundamental to the whole process—some limited but appropriate clinical information could be passed at the same time as the passing of a prescription, to be held with the prescription and drawn down by the community pharmacist. The pharmacist receives information not only about the medicine that may be required on the prescription, but about the diagnosis of the patient, which helps the pharmacist to give better advice and service to the individual patient when they use that pharmacy. We wish to continue to develop that principle as part of the wider e-pharmacy

programme for both chronic disease management and acute management.

Mr MacAskill: More generally, when do you think that we will be able to link prescribing information with patient-based information to facilitate audit and better clinical governance?

Dr Wilson: In a way, that already happens at the level of the individual practice. The individual practice records can be used—and are used—for audit purposes in considering the effectiveness of the use of medicines in treating specific diseases in specific patients. That also will develop further with the implementation of the GMS contract. The information that practices will be incentivised to keep and transmit to central systems will allow much clearer linkage between the medicines that are prescribed and the patients' needs. That can happen already, but the new system will allow it to happen more easily.

Mr MacAskill: What are the links between "The Right Medicine" and the NHS strategy for information? What will be—or is—the overlap and interface?

Mr Scott: "The Right Medicine" should not be seen as a stand-alone document: it is part of our overall strategy for improving care in our health service. Therefore, "The Right Medicine" will be built into the IT strategy and general communications strategies.

Mr MacAskill: On the general issue of governance, how does the NHS strategy link with wider Government IT developments? Are any benefits coming through? Are there any barriers to the strategy?

11:00

Mr Jones: At the highest level, there is a modernising government committee in the Executive. The principal parties to that committee are the Executive, local authorities and the NHS. The chief executive of an NHS trust and I represent the NHS around that table. We are in discussions about, in particular, the issue of single shared assessment for older people and establishing systems that support both the NHS and local government social work departments to ensure that we have a common IT system in place.

Jointly with the Society of Local Authority Chief Executives and Senior Managers, we have also recently established a group to think about the wider issues in communication between local government and the NHS. Our task is to ensure that the NHS and all its partners are linked properly through IT and to think about how all the public bodies in an area can connect. We have just established that group—which has yet to have its first meeting—to start thinking about those wider communications issues.

The Convener: Margaret Jamieson has some questions on repeat prescribing—

Margaret Jamieson:—and reducing waste.

What action has the Health Department taken on containing and reducing waste in prescribed medicines? What is its strategy? According to the report, it is estimated that £15 million-worth of medicines may be wasted each year. In recent years, we have seen moves to introduce bubble packs for certain medicines. Sometimes, when a new drug is introduced to an individual patient, although the patient is given the whole prescription, there is an agreement with the pharmacist to withhold further prescriptions until the patient reports back to their GP that things are settling down and that that is the correct medicine for them. Can you explain to us how you are looking at such issues strategically?

Mr Jones: I shall begin to answer those questions, but my colleagues will want to add to what I say. I guess that there are different levels to the way in which we are addressing the problem of waste. At the highest, strategic level, NHS Quality Improvement Scotland reviews the effectiveness of drugs and issues guidance to the service about how drugs should be used effectively. The Scottish medicines consortium brings together all the area drugs and therapeutics committees of all the NHS boards in Scotland to review the introduction of new drugs. QIS therefore conducts detailed reviews of specific drugs, whereas the Scottish medicines consortium conducts a review of all new drugs that are introduced. The consortium's review is slightly less complex but it deals with a bigger volume of drugs.

In each NHS board area, an area drugs and therapeutics committee reviews prescribing practice. There are also prescribing advisers who work directly with GP practices and GPs, providing advice and support to individual clinicians on their prescribing practice. A lot of things are going on to reduce waste in the system. Bill Scott may want to talk about some of the specific initiatives.

Mr Scott: The most expensive drug that is ever prescribed in the NHS is the one that is dispensed but not taken. We are very concerned about waste. Surveys that were undertaken in Aberdeen and in Ayrshire show the same trends. Around 33 per cent of the medicines that are returned to pharmacies are returned because the patient has died; around 33 per cent are returned because the therapy has been changed; and around 33.5 per cent are returned because the patients have stopped taking them. How do we tackle that? We must tackle it at the front end by improving our prescribing.

If 75 per cent of our medicines are repeat prescriptions, initiating a repeat dispensing system, whereby the patient get can their medicine from the pharmacy for 12 months without anything else being involved, would probably compound the problem. That is why we are trying to build into the system a chronic medication service in which the patient is helped and will discuss with the pharmacist the time frame in which they want their medicines to be supplied. Some people may want a prescription for three months, but others may want prescriptions monthly or even weekly, so we want to engage the patients themselves in that decision making. Our strategy, therefore, is not just repeat dispensing, but repeat dispensing with added value.

We also envisage the repeat prescribing systems of GPs being reviewed periodically to ensure that patients get the medicines that they need at the time, and not the medicines that they were taking the previous year and have stopped taking. We are very concerned about waste.

Margaret Jamieson: Can you say more about the quantity of drugs that are returned unused to community pharmacies? What are you doing centrally to ensure that there is some reclaim?

Mr Scott: We are encouraging the use of patients' own medicines when they come into hospital. There are two reasons for that. First, it makes economic sense. Secondly, it gives the patient the opportunity to be in control of the medicines that they are taking. If you break your leg and go into hospital, you are sometimes treated as if you have broken your head, and your medicines are taken away from you. We are trying to put in place systems where patients are in control.

We have no idea about the conditions under which the medicines that are returned from the community have been stored or whether they have been contaminated in any way. It would therefore be a mammoth administrative task to try to recycle those drugs. That is why I think that the answer lies in the front end. As you suggested, smaller quantities could be prescribed, especially when patients are starting new drugs and testing them out. Of course, for people who pay prescription charges, that could be an issue.

Margaret Jamieson: You indicated that the preliminary findings of the on-going pilot for repeat dispensing are quite positive. Can you say more about the model and its expected benefits? If it is being flagged up as successful, why are you not planning to roll it out until 2005?

Mr Scott: The first pilots that we funded were in Aberdeen and Tayside. They were very successful, but there was a technical problem. When a pharmacist was given a prescription to be repeated for 12 months, they could not cash it in to the pricing division for 12 months, so the pilots had to come up with quite a bureaucratic system to get over that. We then looked into a master-and-slave system, in which there is only one prescription but there are unsigned copies, which are the receipts that go to the pricing division. We want to make the slaves electronic and get rid of that paper to start with. One of the problems—and it is a UK issue—is that of the electronic signature on prescriptions. We have no solution to that yet, and it is a reserved matter.

However, the benefits that we have accrued from having repeat prescriptions, with pharmacists' input and review, show that such a system can reduce wastage and can certainly make a difference to costs. In some cases, costs go up because patients are put on more effective medicines, but then we know that every pound we are spending is a pound well spent with good outcomes.

Margaret Jamieson: You mentioned reimbursement of pharmacists. In the first session of the Parliament, we examined how pricing interfaces with that system. Is the problem that we have still not got that system up and running to provide a straight-through audit process from the issue of the prescription to the pharmacist being paid? There could also be a problem with fraud if individuals say that they are entitled to free prescriptions when they are not. Is the problem that the system is not joined up?

Dr Wilson: Our intention is to ensure that the IT systems that we discussed earlier underpin all the things that Bill Scott has been describing, so that the whole process has a much better audit trail. It will also make the identification of possible fraud much easier. In fact, it will eliminate many of the checks that have to be done. When the community health index number goes on to prescriptions, that will allow people in certain age categories automatically to be regarded as exempt, with no need for any further check. By introducing sensible IT behind existing paper systems, we can make the process much more effective and patient friendly, although, as Bill Scott said, there are still some problems to be overcome in relation to such practical matters as signatures, which we must work out on a UK basis.

Margaret Jamieson: Is that a professional issue or is there some other problem?

Mr Scott: It is a legal issue. The Medicines Act 1968 requires a handwritten signature on the prescription, as does the Misuse of Drugs Act 1971. The technical issue surrounds what an electronic signature would be.

Margaret Jamieson: When was the legislation last updated?

Mr Scott: There are new statutory instruments all the time, but the act itself was passed in 1968.

Margaret Jamieson: Before the electronic age.

Susan Deacon: I would like to follow up on a number of the issues that have been covered in response to Margaret Jamieson's and George Lyon's questions. We have heard a great deal about the range of work that is under way, but could Trevor Jones and the other witnesses tell us how satisfied they are with the pace of developments in general?

Mr Jones: I guess that we would all like to move faster, but we have to think about the history of IT development in the NHS. Until relatively recently, it was for individual NHS bodies to develop their own IT solutions, but I can give you a simple example of what has happened as a consequence of that. For financial ledgers—a very basic system for any organisation—we have 27 different systems working in the NHS in Scotland. We have a disparate range of systems performing similar functions in NHS bodies, which slows down our ability to develop a national IM and T strategy as fast as we would like.

Last year, during a review of management and decision making in the NHS, a sub-group looked at IM and T. A strong recommendation from that group was that we should return to national systems, supported nationally, for all the major processes in the NHS. That is the direction that we will move in. We have now set up the e-health project board, which the Minister for Health and Community Care will chair. As we move back to national systems—perhaps not a single IT solution for all processes, but no more than two or three and certainly not 27—we will be able to roll out new IM and T systems much faster.

We must also remember how complex the NHS is and how many community pharmacists and GP practices there are. Margaret Jamieson said that 2005 feels a long time away, but when one considers the number of pharmacies and GP practices involved and the number of months between now and 2005, it does not feel that far away. From where I am sitting, the target for completing that roll-out feels very close.

11:15

Susan Deacon: I appreciate your answer and I understand the complexity of the situation. However, it is striking that the Auditor General's report gives a number of examples of systems that have not been rolled out at the pace that might have been expected, such as the master-and-slave repeat prescribing model to which Bill Scott referred, which was reported on in 2001 and seemed to be widely accepted as a way forward.

Is it not the case that there is a danger of a significant failure to meet patient expectations? We live in a world in which an individual can, for example, go to a cash machine in just about any developed part of the world and use their cash card to access their bank account. However, people still physically have to take bits of paper, often handwritten, between GP practices and pharmacies and, in turn, between GP practices and hospitals—between primary and secondary care. How do you plan to manage the process of meeting patients' expectations, given that people are used to increasing amounts of information technology in other walks of life?

Mr Jones: That is absolutely the direction in which we must go. I understand that people have justified concerns and frustrations.

Derek Wanless, a former chief executive of National Westminster Bank, was appointed by the Chancellor of the Exchequer about 18 months or two years ago to review the financing of the NHS. When he reported on the UK-wide resource requirements for the NHS, he expressed the view, based on his experience in the financial sector, that the NHS was underinvesting in information management and technology systems by a factor of 10. As development funds come into the service, there is always pressure to invest in direct clinical services and in more doctors and nurses. In an NHS board situation, it is sometimes difficult to allocate development funding to IM and T, rather than to additional nurses at the clinical coalface and I think that that is why we are in the current position in relation to IM and T. The clinical priority has always been greater than that for investment in basic IM and T infrastructure. We recognise that now and—critically in relation to remote and rural areas—we need to have IM and T solutions in place in Scotland.

The current method of providing health services is not sustainable. We must think differently about how health services will be provided in future and IM and T must lie at the heart of that. That is why we have laid so much emphasis in "Partnership for Care" on developing the e-health agenda. However, the fact is that IM and T investment is starting from a low base. It will take time for that investment to reach the level at which it should be.

The Convener: As we are coming to the end of this subject, I ask for clarification on one point. Bill Scott talked about how reduced dosage might allow more regular monitoring, which would be helpful. However, there was of course the difficulty that that would lead to more prescriptions being issued—and more levying of the prescription charge. Irrespective of the impact on the individual, who might be paying for their prescription as opposed to receiving it free, are you saying that although reduced dosage might

lead to initial savings because monitoring would allow GPs to change people's drugs or decide that certain drugs were not needed and so on, such savings would be lost because the increase in prescriptions would eat into budgets elsewhere?

Mr Scott: The chemist remuneration aspect would not be affected, as we would have to change that anyway. There might be some small effect on costs of ingredients. I emphasised that the patient who pays for a prescription would consider it unjust and unfair if they were given only a fortnight's supply of a drug when they were used to getting a supply that would last two or three months.

The Convener: Your point was about the impact on the patient rather than on budget transfers. That is helpful.

I think that we have exhausted questions on repeat prescribing, so we will move on to the management of patient expectations and patient compliance.

Rhona Brankin: You said in "The Right Medicine" that, during 2003, you would run a number of major public awareness campaigns about the safe use, storage and disposal of medicines. Where are we with those public awareness campaigns? Are they likely to cover issues such as the overuse of antibiotics?

Mr Scott: We have had campaigns about the use and overuse of antibiotics. This year, we also plan to have what is known as a dump campaign, to encourage patients throughout the country to return their unwanted medicines.

Rhona Brankin: When is that dump campaign happening?

Mr Scott: We plan to run that campaign before December.

Rhona Brankin: I would like to go on to look at section 3.2 of the main report. We all agree that patient compliance is important, but there is also a need to use NHS funds as effectively as possible. Will your public awareness campaigns highlight to the public the extra cost of some types of preparations?

Mr Scott: We had not intended doing that. There is a balance between helping the public to understand the cost of medicines and ensuring that people who are taking certain medicines do not feel inhibited about taking them because they feel that they are far too expensive. On the other hand, they may feel that not enough is being spent, so we have to be careful about costs.

Rhona Brankin: Would you not see it as helpful to be able to highlight those costs to patients?

Mr Scott: The helpful thing would be to highlight the cost of the overall waste.

Rhona Brankin: Maybe you would want to highlight some of the associated costs in a public way, rather than to individual patients.

Mr Scott: Yes. In fact, the schemes in Aberdeen and Ayrshire made health care professionals aware of the costs and of the type of medicines that were most frequently being disposed of unused.

Rhona Brankin: We would be interested to find out how GPs can be encouraged to consider the extra cost of premium-price products against the likely improvement in compliance by individual patients.

Mr Scott: I notice from the report that there were some major savings on premium-price products, and I can see good reason why that was said. On the other hand, if you are on four medicines, or if you are a forgetful person, premium-price medicines such as slow-release agents or patches are cost-effective because you are actually taking them. If doctors give medicines that have to be taken three times a day and the patient does not take them, that is another waste. A balance must be struck, and a clinical decision must be made by the GP at the time of prescribing.

Rhona Brankin: That is important.

Mr Scott: Very much so.

Margaret Jamieson: I would like to find out what the Health Department is doing to build up a body of evidence to assess the effectiveness of new medicines compared with existing medicines.

I am well aware that pharmaceutical companies go for a licence for a new medicine at a UK level or, as is happening increasingly, for a European licence. Then that medicine has to go through the rigours of consideration by the National Institute for Clinical Excellence, the health technology assessment directorate of NHS Quality Improvement Scotland and the Scottish medicines consortium. You have also indicated that all the health boards conduct their own assessments. Finally, the medicine goes to trusts and local health care co-operatives. What benefit is there in all those organisations doing virtually the same job?

Mr Jones: Let me start by saying that they are not doing the same job; they are all doing different jobs. You must remember that we are talking about £800 million worth of expenditure, so having sophisticated systems is justified, as the report shows.

For the introduction of a new medicine, the Scottish medicines consortium provides the first review. All 15 NHS boards come together to assess the effectiveness of that new medicine. The SMC produces guidance for the 15 NHS

boards about whether the new medicine is more effective than existing therapies and about whether it should be used. There is continuing discussion about whether the recommendations of the Scottish medicines consortium should be compulsory; I discussed the issue yesterday with the NHS board chairmen. At the moment, the SMC's recommendations are guidance, which can result in a drug's being prescribed in one part of Scotland, but not in another.

Margaret Jamieson: That is postcode prescribing.

Mr Jones: Yes. Yesterday, we had a debate about whether it should be compulsory for the national health service to take up the SMC's recommendations. If a medicine is effective, the debate should not be about whether it is available throughout the country, but about when it should be available and how it should be introduced. Following yesterday's meeting, I will be having discussions on that with the wider NHS.

That is the first hurdle that a drug has to overcome before it would be prescribed generally in the health service. Certain medicines, particularly the high-priced medicines, could be subject to a much more rigorous review by NHS Quality Improvement Scotland, but that review is different to the one that the SMC carries out; it is a much more sophisticated review of a drug's effectiveness. Fewer drugs—the higher-priced drugs—go through that process, but that is a different issue.

The area drug and therapeutics committee of each NHS board considers the day-to-day management of the prescribing process. The committees assess how to develop comprehensive systems for the whole of an NHS board area, which includes consideration of issues such as moving to single joint formularies. One could say that those committees examine the operational end of the business. Bill Scott might want to discuss some of the technicalities that are involved.

Mr Scott: When a medicine is licensed, either through the European scheme or in this country, what we are interested in is that it is of good quality, does what it says and is safe. We do not have a fourth hurdle. One could argue that building a fourth hurdle into the licensing process might save all the other processes down the line. However, it costs about £350 million to develop a medicine and, if we built in a fourth hurdle, we would add not only a substantial extra cost, but a further delay in getting those new medicines to the marketplace.

Margaret Jamieson: Have you not in fact introduced a further delay by having consideration by the SMC, boards and all the rest? Trevor Jones said that there is a sophisticated process, but I do not think that the system is sophisticated, because we still have postcode prescribing.

I believe that what is missing in the chain is the cost in terms of improved quality of life for the patient. Consider the social aspects: if a doctor prescribes drug A, the individual will be absent from work for a shorter time and, during that time, their quality of life will improve day by day and week by week. That does not seem to be included in the cost; only the cost of the product is considered.

11:30

Mr Scott: The reason why that factor cannot be included initially is that, when a medicine has its licence and is launched, there is often a paucity of data about its cost-effectiveness and cost outcome. The SMC has to work with the information that it is given by the industry and from clinical trials. The SMC is an important development in Scotland and it has not yet been duplicated in the UK. The SMC allows a group of experts to look at the data that we have and then to give an indication to all the health boards about where that new medicine lies in the armamentation of clinicians. If it were not for the SMC, every health board would have to try to duplicate that process, but the current arrangement is an efficient use of resources. We do not have enough specialists in Scotland for all the new medicines, but every health board could conduct the same process if it wanted to.

Mr Jones: It is worth adding that the SMC was created in 2001, and that before that, individual area drug and therapeutics committees were reviewing the same drugs. Sometimes they came up with different conclusions, which reinforced postcode prescribing.

Mr Scott: Another issue is that, when some medicines are launched, they might not seem to be performers, so one must gather some clinical experience. Statins are a good example and they are now at the top of the league table in our drug bill.

Dr Wilson: We need to complement a national approach with an individual patient approach. We have been talking about clinical effectiveness and cost-effectiveness on a Scotland-wide basis and sometimes on a UK-wide basis. It is important that that information is available to the prescriber—normally the GP—when they have a consultation with a patient, so that when the decision is made to prescribe a medicine, the individual prescriber considers all three aspects—the clinical and cost-effectiveness of the drug and the individual circumstances of the particular patient. The third element cannot be dealt with at national level; it

can be dealt with only on an individual basis between the GP and the patient.

Margaret Jamieson: That takes us back to the new GP contracts. It is for the GP to determine to which drug they put their signature. Is it not true that GPs are now being forced down a road where their independence and professionalism are somewhat compromised? If, when a GP enters the name of a drug that they want to prescribe into the IT system, a red light starts flashing and an alternative drug is flagged up, will they prescribe the amber drug, rather than the one that they believed would be better for the patient, if they know that they are getting to the edge of the budget?

Dr Wilson: That takes us back to the discussion about audit, which is a peer-based system that allows others to check whether what is being prescribed by an individual GP for his or her patients is clinically appropriate. That system will include the issues that you mention. You are right—we need to complete that full circle to ensure that clinical audit is part of that process.

The GMS contract does not force practitioners down a line of prescribing any particular drug. The IT system that practitioners have might encourage them to prescribe generically—a process that the report strongly supports—but the system also allows the clinical decision to be made to override that system and for GPs to say, "In these circumstances, we think the following drug ought to be prescribed".

Margaret Jamieson: Has the effectiveness of alternative treatments been evaluated?

Dr Wilson: Are we talking about alternative drug therapies such as homoeopathy?

Margaret Jamieson: Yes, anything like that.

Dr Wilson: I was not sure what you were after, so I will pass that question to Bill Scott.

Mr Scott: As you know, the efficacy and safety of alternative medicines have not been evaluated as rigorously as those of conventional medicines. However, the European Parliament is considering licensing certain homoeopathic and herbal remedies. People in the homoeopathy hospital in Glasgow have told me that they are conducting trials of products. I understand that the chief scientific officer is funding four different trials, but I do not have the details. The CSO would look favourably on funding applications from practitioner specialists or academics who are interested in assessing products and practice.

Margaret Jamieson: That is interesting. Thank you.

Rhona Brankin: I want to explore that area a bit further. If a patient asked their GP for herbal or homoeopathic treatment, would the GP give it to them?

Mr Scott: Yes.

Mr Jones: That would depend on the patient's clinical condition.

Rhona Brankin: Absolutely.

Mr Jones: It would depend on whether the GP agreed that there was a clinical need. Some GPs are particularly interested in alternative therapies and will provide them directly, but they can and do refer patients.

Rhona Brankin: Is such referral part of GPs' training? Is there postcode prescribing for alternative treatments or does prescribing depend on a particular GP's interest in, for example, homoeopathy?

Mr Scott: There is no postcode prescribing, but it probably helps if a GP is interested in alternative treatments such as homoeopathy. However, a GP can refer a patient to other practitioners. In fact, prescriptions are given on the NHS for homoeopathic preparations.

Rhona Brankin: What about the new practice of GPs referring patients to, for example, health clubs? How common is that practice and how is it evaluated? Is that sort of practice now included in GPs' training? I am interested in the whole business of value for money and why we rely so heavily on drug therapies rather than alternatives to them. It seems to me that one barrier to using alternative treatments is that they have not been evaluated in the same way as drugs that pharmaceutical companies produce have. What can we do to open up the situation and provide more choice for patients and doctors?

Mr Jones: We now take a much wider view of health. For example, prescribed exercise in health clubs is now encouraged. Hamish Wilson may be able to indicate where that is available. In the Borders, where I live, a patient can be referred to a fitness centre—indeed, I suspect that some of us should be referred to fitness centres. It is critical to take a wider view of health. Rather than think traditionally about the illness side, we should think about critical preventive issues such as exercise and diet. We must find all sorts of ways of encouraging the population to adopt different lifestyles. The NHS and GPs are good sources of health improvement advice.

Dr Wilson: There is an increasing use throughout Scotland of alternative outlets, if I can put it that way. That does not necessarily mean writing a prescription for alternatives, although some GPs give prescriptions to a patient that they can take to their local exercise club, for example. GPs are increasingly working among themselves and with others, such as local authorities, to

promote healthier lifestyles, as Trevor Jones mentioned. Those schemes work best where they are carried out in partnership between the NHS and other local bodies, including voluntary sector organisations and local authorities.

In addition to homoeopathy, some GPs deliver alternative therapies or will refer the patient to practices that provide them. Acupuncture is one example. The range of opportunities is increasing, but you are right to say that alternative therapies have not yet undergone the same evaluation as has been applied to the much longer-standing set of therapies around medicines.

Rhona Brankin: I promise that this will be the last question, convener. What barriers still remain? Are alternative therapies being evaluated in terms of value for money? It strikes me that we talk all the time about comparing different drugs, but we do not take a value-for-money approach to comparing those drugs with the different approaches and techniques. Are we not missing a trick?

Mr Jones: I am not sure that there are barriers. As with all new developments, it takes time to develop momentum and to move on, but I do not think that there are particular barriers.

Rhona Brankin: Who pays for the trials of the drugs that are produced by pharmaceutical companies? How difficult is it for alternative therapies to compete?

Mr Scott: For clinical trials, there is a mixed economy, in that the industry pays for materials and NHS staff get involved in undertaking the trial with the patient's consent. For alternative therapies, there is a need for an academic infrastructure to help to get a balanced trial. There are issues about how one gets a true double-blind clinical trial with some of those therapies. As momentum builds up and we see more practitioners of such therapies taking an interest academically, we may get a body of people who will want and will have the skills to undertake those trials.

Susan Deacon: I have a brief supplementary to Margaret Jamieson's question on the safe storage, use and disposal of medicines. Some time was spent talking about public awareness campaigns and measures being taken at a national level. I want to ask Bill Scott about the measures that are being taken at a local level and, in particular, about domiciliary visits by community pharmacists. I am aware that, where such visits have been developed, they have been effective at the level of the individual patient in terms of both safety and cost-effectiveness. I think that a commitment was made in "The Right Medicine" to develop those visits. Has progress been made on that?

Mr Scott: "The Right Medicine" indeed contains a commitment to develop those services. Sadly, pharmacists who carry out such home visits do so after work because of the need to get the right manpower balance in our pharmacies. However, we are committed within our contractual process to allow pharmacists to undertake domiciliary visits where that is appropriate. I should also say that most pharmacies in Scotland will take back unwanted medicines. The local health board will pay for the uplift and safe disposal of those from the pharmacies.

The Convener: We move on to the subject of how prescribing by GPs and independent contractors can be influenced.

George Lyon: I have three questions on the new GP contract, which is to come into force next year. One health board chief executive described the new contract to me as the most fundamental and far-reaching change in the NHS. I do not know whether he is right or wrong, but the contract will clearly have a role in influencing the way in which GPs prescribe. Hamish Wilson said that it will incentivise GPs. Can you explain how it will do that and what impact you believe it will have?

11:45

Mr Jones: It might be useful if Hamish Wilson gave the committee a brief overview of the GMS contract—it is not just a GP contract; it is for all staff in primary care—and how that relates to prescribing. That will put the discussion into context.

The Convener: Certainly. Go ahead.

Dr Wilson: It is interesting to hear the GMS contract described as one of the most fundamental changes to the NHS. It is a significant change to the way in which general medical services will be delivered by GPs and other members of the primary care team.

One of the most important parts of the GMS contract—and something that is unique to the United Kingdom—is the inclusion of the quality and outcomes framework. Across 10 clinical areas—although that can be reviewed in future—the framework sets out a range of indicators against which practices will measure themselves and be measured.

Prescribing the appropriate medicine by having the right information about the patient and ensuring that the right medicine is prescribed for that patient is a key part of those 10 clinical areas. The indicators in each of the 10 areas will encourage and incentivise prescribing that is in line with nationally accepted, good clinical practice. The quality and outcomes framework has been based on national evidence.

Another aspect of the quality and outcomes framework relates to how the practice is organised

and delivers its services to the whole population and not just to individuals. The organisational framework contains a specific section on medicines management, which sets out a range of criteria against which practices will be measured. Part of that is about whether the practices have medication review systems in place for individuals and prescribing advisers, who will be available to help practices to improve the quality of their prescribing.

The third element of the quality and outcomes framework is the patient's view. The framework contains a section to ensure that patients' views are taken on board. Those three elements are what make the GMS contract substantially new.

A practice will get points to reward them for achieving certain levels against the criteria that are set out in the framework. Depending on the points that it achieves, the practice will get a sum of money. The scorecard is quite complex and I am happy to let the committee have a copy of it. The practice's information systems will tot up the points with which it has been rewarded at the end of the year. That result will be audited and there will be a visit from the local primary care organisation—trust or health board—and a discussion about the points that the practice has achieved; the reward will follow. A substantial part of the new GMS contract is about rewarding quality. An important part of the quality of service is appropriate prescribing. That brings us full circle and back to the question that was asked.

George Lyon: What impact do you think the contract will have? Will it be positive? What is the likely outcome? What is the hope?

Dr Wilson: If we start with the patient's perspective, the quality and outcomes framework is based on good clinical practice, as evidenced by international standards. The more a GP performs in line with the quality and outcomes framework, the more effective the clinical service will be. The contract is seeking to do nothing more than to reinforce what is already available, but to do so in a specific and structured way. The implementation of the contract can be helped by the advice and support mentioned in the Audit Scotland report; those areas of support will still be available, whether it be community pharmacists or practice pharmacists working with practices or prescribing advisers working with primary care trusts or boards. From the point of view of the patient, clear benefits in quality of care and appropriate prescribing ought to flow from the new GMS contract.

Mr Jones: We should be able to see greater emphasis on the quality of care and greater reward for high quality. Whereas the old contract rewarded volume—items of service—there is a much harder focus in the new contract on improving the quality of the service provided.

George Lyon: I understand and acknowledge what you are saying, but what impact will there be on your prescribing costs? Will they be increased or decreased? Will waste be eliminated? What is your view on the likely impact?

Mr Jones: We will get more effective prescribing, with the right drug being prescribed in the right quantity for the particular patient's needs. The measures are not being introduced just to save costs. They are not about reducing prescribing costs; they are about improving the quality of prescribing.

George Lyon: I understand that, but what impact will they have on the budget? You must have some idea.

Mr Jones: We have not assessed that and it would be wrong to put figures on it. A complex equation would be required to answer that question.

Rhona Brankin: Could we have an idea of the additional cost of the new contract?

Mr Jones: We know the additional cost of the GP contract. Do you have the figure in your head, Hamish?

Dr Wilson: Yes—but not in relation to prescribing, which was being asked about. Additional funding is being allocated to support the implementation of the new GMS contract through delivery of services at practice level. The increase is one of approximately 33 per cent over the next three years over the current investment in general medical services. A whole lot of that increase relates to improvements in premises and in IT. It also relates to employing more staff in primary care—not just GPs, but nursing and support staff. A specific amount for any changes that might occur as a result of changes in prescribing is not, however, included in that increase. That amount is a separate cost, which does not come under the GMS contract.

George Lyon: So you have not evaluated that cost.

Mr Jones: Given the issues involved, I do not think that we can. The report identifies a potential £14 million of savings, but recognises that that amount will always be tiny compared to the variation in drug costs, given changes in the products that come on to the market, which will continue. History tells us that drug costs will rise at a rate of about 9 or 10 per cent a year over the longer term—although that figure has been slightly higher over the past three or four years. New products will continue to come on to the market, and it is not possible to forecast what they will be. That is why I will not try to put numbers on changes relating to prescribing, which would be nonsense. The contract should help to ensure the

most appropriate drugs being prescribed in the most appropriate quantities. It does not matter whether that increases or decreases cost; that will depend on what is coming into the system and on the needs of patients.

George Lyon: I seek further clarification about the position with regard to salaried GPs. Is it easier to influence what they do than what independent contractors do?

Dr Wilson: There are currently very few salaried general practitioners, the vast majority of whom are employed within practices. We therefore do not have a large cohort of salaried GPs on which to base anything. All GPs, whether they are salaried GPs or independent contractors, go through the same training system, have the same ethical code and have the same requirements. Whether they have a terms-of-service contract or an employment contract, they are there to provide the best clinical care that they can for the patient. They have also to take into account the needs of the whole community that they serve. There is always a balance to be struck. In that context, a salaried general practitioner is no different from an independent contractor with regard to the clinical requirements that are placed on them.

Mr Jones: In general, the service has a very good relationship with GPs, and we do not have a major problem with influencing them. They want to work with their colleagues in secondary care and to think about how care might change. The direction in which we are going is to think much more about the total patient experience. We are developing managed clinical networks to link primary care with the care provided in district general hospitals and specialist centres. We are finding new mechanisms to bring clinical staff together in those groupings to address the patient experience. That work is going remarkably well. Like other health care professionals in Scotland, general practitioners are keen to work on that agenda. The way in which clinical professionals are working together in the Scottish health service is positive.

Susan Deacon: I would like you to clarify something. Will the new GMS contract change clinical practice in respect of prescribing practice? If we say that the relationship with GPs in Scotland is such that things will progress by means of co-operation, influence and so on, the implication is that contractual change is neither relevant nor necessary. Hamish Wilson said that salaried GPs are no different to independent contractors in terms of clinical practice. The logical implication of that statement is that any change to the contractual mechanism would be neutral in terms of its impact on prescribing practice. Is the contractual arrangement germane to prescribing practice?

Mr Jones: Yes it is. In order to improve the health service in Scotland, the key issue for staff is that the right remuneration be geared to the right set of issues. That is why we are bringing in new contracts not just for GPs but for all NHS staff. The GP contract, with its focus on quality, is another tool to help us move that agenda forward. Although the GP contract is not our only tool, it is an important one and I have no doubt that it will help.

Dr Wilson: Perhaps I should clarify that the contract will be made available and applicable to the whole spectrum of GPs. We do not seek to distinguish between independent contractors and salaried GPs. In future, for a range of reasons that are outlined in the GMS contract, some GPs might choose to go down the salaried route.

As Trevor Jones said, this is the first time that the quality of clinical care, part of which is the quality of prescribing, is to be rewarded more overtly than has been the case in the past. The new GMS contract will reinforce the efforts that people have made to improve the cost-effectiveness of prescribing.

That said, all of us struggle with the fact that we do not know the extent and nature of the effect that the change will have. What we are doing has not been tried elsewhere in the developed world and we do not know what the end result will be. There is strong evidence that this is the right path down which to go; however, we do not know as yet what the cost might be.

George Lyon: I have one more question. Earlier this morning we heard about limitations on existing IT systems and about the need to improve those systems—Trevor Jones acknowledged that. Given that background, how will the department know whether a GP has achieved the performance targets that are set out in the quality framework?

As you said, the integrated nature of the framework means that much measurement will have to be done. Have you got processes in place by which to measure performance in order to offer the rewards? Clearly, if you cannot measure performance, the contract is not worth the paper on which it is written.

Dr Wilson: As we speak, all of the main GP system suppliers are working hard to ensure that the IT systems that GPs use in their practices are of good enough. Practices and health boards need to be able to log on to access the information that they require and we need to ensure that the information is available and that it can be audited.

The bulk of the new contract comes into effect in April 2004. It will need to be followed through into the next financial year, so the IT systems have to be available at that point. A national system, which is the equivalent of accreditation, will ensure that

the systems are fit for purpose. The systems will include those that are used at present by general practitioners throughout Scotland.

George Lyon: Will that be done in the form of a yearly audit of the system and a tallying-up at the end of the year of the points and payments that have been made?

Dr Wilson: Yes. The GP system will do certain things, but there will also be an independent audit of the result.

The Convener: Thank you for that. We have a couple more questions on costings. George Lyon will ask the first, which is in reference to section 4.2.1 of the main report.

12:00

George Lyon: To what extent does the Health Department share with the health boards the assumptions about increases in drug costs in calculating the budget uplift every year?

Mr Jones: We publish trends in prescribing practice on NHS Scotland's information and statistics division's information system. That information is available to NHS boards.

George Lyon: That is the total sharing of information.

Mr Jones: Yes. That is how the budget varies. Some detailed documents are published—one came out this morning—about overall trends in drug costs. That information is made publicly available to health boards to help them to understand what trends might be in their budgets. They also have to take into account local variations. For example, if there was a cancer treatment centre in its area, a health board's rate of drug inflation could be different because of high-cost cancer drugs. Budgeting for that would be done locally.

Mr MacAskill: What action are you taking to ensure that there is a full costing of evidence-based guidance on the implementation of new medicines?

Mr Scott: We will have some idea of the impact that the SMC's decisions will have on NHS boards. When the SMC writes to NHS boards with its decisions, they can see how that impinges on the boards.

The Convener: Does anyone have a final question?

Rhona Brankin: I would like to explore a little further the business of comparisons between different medicines. When the effectiveness of different medicines is compared, are those trials called head-to-head trials? I read an article in the *British Medical Journal* on a proposal in the United States to conduct more such trials. It talks about the use of diuretics being as effective as other treatments for hypertension. Where are the head-to-head trials going on? Do they involve just new drugs that are being tested by the drug companies?

Mr Scott: I am sorry, but I am not familiar with the phrase "head-to-head trials". The sort of trials that have been conducted in the past have involved testing a medicine against the gold standard. We are now interested in the relative efficacy of medicines when they are tested against other groups in a pharmacological class. Some of those trials are conducted in the health service or in our university departments.

I cannot comment on the use of diuretics to treat hypertension. Diuretics are a first-line treatment for mild hypertension, although they do not act as diuretics.

Rhona Brankin: Does the National Institute for Clinical Excellence look for evidence that a treatment is appreciably better than what is already available before it advocates its use in the NHS?

Mr Scott: I could say that that is an English Department of Health initiative. NICE looks at the cost-effectiveness of a product and its economic impact and judges that against what is already in the marketplace.

Rhona Brankin: Are the results of that are used in Scotland?

Mr Scott: QIS would examine that evidence and come to a view on its relevance to the Scottish health service.

The Convener: There being no further questions, I thank Mr Jones, Dr Wilson and Mr Scott for giving us evidence this morning. It has taken a little bit longer than we anticipated, but it has helped to satisfy the demands of the committee. Thank you for your time.

We will take a five-minute comfort break before we go into private session.

12:05

Meeting suspended until 12:12 and thereafter continued in private until 13:08.

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