AUDIT COMMITTEE

Tuesday 11 January 2005

Session 2

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AUDIT COMMITTEE
1st Meeting 2005, Session 2

CONVENER

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

DEPUTY CONVENER

*Mr Andrew Welsh (Angus) (SNP)

COMMITTEE MEMBERS

*Susan Deacon (Edinburgh East and Musselburgh) (Lab)
*Robin Harper (Lothians) (Green)
*Margaret Jamieson (Kilmarnock and Loudoun) (Lab)
*George Lyon (Argyll and Bute) (LD)
*Mrs Mary Mulligan (Linlithgow) (Lab)

COMMITTEE SUBSTITUTES

Chris Ballance (South of Scotland) (Green)
Mr Ted Brocklebank (Mid Scotland and Fife) (Con)
Marlyn Glen (North East Scotland) (Lab)
Mr John Swinney (North Tayside) (SNP)

*attended

THE FOLLOWING ALSO ATTENDED:

Mr Robert Black (Auditor General for Scotland)
Angela Cullen (Audit Scotland)
Caroline Gardner (Audit Scotland)
Barbara Hurst (Audit Scotland)

THE FOLLOWING GAVE EVIDENCE:

Mr John Aldridge (Scottish Executive Finance and Central Services Department)
Mr Trevor Jones (Former Head of Scottish Executive Health Department and Chief Executive of NHS Scotland)

CLERK TO THE COMMITTEE

Shelagh McKinlay

SENIOR ASSISTANT CLERK

David McLaren

ASSISTANT CLERK

Clare O'Neill

LOCATION

Committee Room 5

Scottish Parliament

Audit Committee

Tuesday 11 January 2005

[THE CONVENER *opened the meeting in private at 09:33*]

09:42

Meeting continued in public.

Items in Private

The Convener (Mr Brian Monteith): I welcome members of the public and representatives of the media and various public bodies to the first meeting in 2005 of the Scottish Parliament Audit Committee.

Under agenda item 2, I seek the committee's agreement to take items 7 and 8 in private. Item 7 is consideration of the committee's approach to the report by the Auditor General for Scotland "Overview of the financial performance of the NHS in Scotland 2003/04". Item 8 is consideration of the evidence that we will take at item 4 on the Auditor General's section 22 report "The 2003/04 Audit of Argyll and Clyde Health Board". We usually take such items in private. Do members agree to take items 7 and 8 in private and to consider in private at our next meeting lines of questioning for our inquiry into the 2003-04 audit of Argyll and Clyde NHS Board?

Members *indicated agreement*.

"Overview of the financial performance of the NHS in Scotland 2003/04"

09:44

The Convener: We move on to item 3, which is a briefing from the Auditor General for Scotland on his report "Overview of the financial performance of the NHS in Scotland 2003/04". Members will recall that we received a brief introduction to the report from the Auditor General at our last meeting, because the report had been published in that week, but that time constraints were such that there was not a great deal of opportunity for discussion. The item is on our agenda again so that we can consider additional matters that the Auditor General or a member of his team might want to bring to the attention of the committee and so that members can ask questions.

Mr Robert Black (Auditor General for Scotland): Thank you very much. At the previous meeting, I took the opportunity to give the committee a brief introduction to the report and I endeavoured to answer the questions that were posed. I promised that we would come back to a subsequent meeting with further information on one or two matters that came up. We are now in a position to do that. Of course, we are also happy to endeavour to answer any questions that committee members might have in addition to those that were posed when we last met.

With the convener's agreement, I will invite Barbara Hurst to cover the points that are outstanding from the last meeting, according to our records.

The Convener: Certainly.

Barbara Hurst (Audit Scotland): At the previous meeting, Margaret Jamieson asked a question about the monitoring of ring-fenced money. We have gone back to our auditors of the health boards and the Health Department to check on that. The auditors of the health boards tell us that there are varying degrees of accountability on ring-fenced money and that the Health Department monitors some of it, but not all of it. The department's auditor tells us that that depends on which policy branch within the department is responsible for allocating the ring-fenced money. In essence, it monitors some but not all of the money.

Susan Deacon asked a question about the impact of changes to the allocation of funds throughout the year. We went back and took Argyll and Clyde as an example. The changes amounted to £15.5 million, which is just over 3 per cent of its revenue resource limit, but some of the changes

are tiny, so a little bit of micro-management is probably going on there.

Susan Deacon also asked about the Health Department's £500 million spend. We have managed to track about £400 million of that figure. The committee might want to pick up with the Health Department the question of what the rest of the money covers. The sorts of area that are covered are the department's running costs and capital and depreciation. Some of the bigger figures are around the research budget, welfare, food, nursing bursaries and nurse education and training. If it would be helpful, we could provide the committee with a clean copy of that expenditure.

The Convener: Thank you. Members may now ask any questions that they have about the briefing or the published report.

George Lyon (Argyll and Bute) (LD): I have two questions. The first one is about the revaluation of property. The report states that the boards experienced significant difficulties last year because of delays in the revaluation process and that there was a change in the methodology for calculating capital charges. Can you explain in more detail what the likely impact of that is? Is that cash that the boards will have to pay back to the centre and so which is taken straight out of the system at the start of the financial year? If you answer that question first, I will follow up with a second question shortly.

Barbara Hurst: This is not my "Mastermind" subject, but I will try to answer the question and Angela Cullen can pick up afterwards.

There were serious difficulties around the revaluation of property. A different valuer was used this time round, which meant that some boards were losers and some were gainers in respect of the capital charges that they would have to pay. Overall, the revaluation is more or less cost neutral to the health service, but that does not help boards such as Greater Glasgow NHS Board, which will have to pay more in future years.

I am slightly shakier on the change in methodology, but I think that, as a result of the revaluation, something to do with the indexation means that there will be a slight increase in 2004-05 that was not picked up in 2003-04. The revenue resource limit was not reduced in 2003-04, so, in theory, the money is still sitting there but, as we know, there has been significant pressure on boards, so they will take a double hit on that in 2004-05. We saw that in the sums that Argyll and Clyde NHS Board provided to the committee.

George Lyon: My second question is about the estimated costs of the pay modernisation initiatives. At the end of the day, you could not publish a copy of the boards' estimates of those costs. Will you go into more detail about the differences between the Health Department and the boards on where the problems lay?

Mr Black: I think that I mentioned that, on 21 December, I wrote a letter to the acting accountable officer of the department, Ian Gordon, to ask whether he could help with our understanding of the extent of the differences between the boards' estimates and the department's estimates and the reasons for them. I have not yet had an answer to that letter, but as soon as I have it, I will make it available to the committee.

George Lyon: Did you get estimates from all the boards?

Mr Black: There were two problems. One was that not all the boards were able to provide us with estimates. The second concern was that the boards might not have been providing us with figures on a common basis. We were unable to get behind that to produce a reasonably robust figure for the whole of Scotland in which we had confidence.

George Lyon: Which boards could not provide information?

Barbara Hurst: We did not get figures on the general medical services contract from, I think, Greater Glasgow NHS Board and Lanarkshire NHS Board. As those are two of the bigger boards, their figures affect the national one.

George Lyon: Was it just for the costs of that one contract that those boards could not give you an estimate?

Barbara Hurst: Sorry, it is hard to remember back, but I think that all the boards were able to give us the figures for the consultant contract.

George Lyon: What explanation was given for the boards' inability to give an estimate of the figure?

Angela Cullen (Audit Scotland): They were still working on the figures. I presume that they were using the formula that the Health Department had given them and were working on their local figures. They are still working on them.

George Lyon: So you will get the figures at some stage.

Angela Cullen: Yes.

Mr Andrew Welsh (Angus) (SNP): I am concerned about shaky rather than robust financing and about some of the assumptions that have been made about non-recurring funding and high levels of savings. I have a question about the funding gaps for 2004-05, which are proposed for seven boards and which will total £162 million. I note that Lanarkshire NHS Board's situation is

similar to that of Argyll and Clyde NHS Board in that there was an overspend in 2003-04 and there will be a funding gap in 2004-05. If the boards start out that way, the chances are that the gap will get worse rather than better. How big a problem is that and is it likely to be tightly controlled or not?

Mr Black: It might be more appropriate to put that question to the Health Department's accountable officer, if the committee is going to take evidence from the department at a future meeting. That is very much an in-year issue with an element of projection to the end of the financial year. The people from the department are best placed to give an answer to that.

Mr Welsh: You have rightly flagged up a potential major problem.

Susan Deacon (Edinburgh East and Musselburgh) (Lab): The report shows that the rising cost of drugs once again accounts for a substantial part of the spend and will absorb a substantial amount of the increased resources that are going to the health service. That is not by any means the first time that you have made that observation, but I note that in this report you say little about it, other than to make the observation. Will you elaborate on whether the situation has improved or deteriorated relative to previous increases in the cost of drugs? Such costs cause pressure points elsewhere, so can you compare how Scotland fares with other parts of the United Kingdom or with other health systems in the world? How does the position in the current report relate to other reports that you have done, such as your work on general practitioner prescribing costs? Have the recommendations that you made on that issue been taken on board and are they having an impact on the size of that part of national health service spend?

Caroline Gardner (Audit Scotland): The last time we reported on GP-prescribed drugs was in 2002, which was a follow-up to the report that we published in 1999. We found that most health boards had made considerable progress on improving the cost-effectiveness and quality of their prescribing. The problem was that, at the same time, not only the cost of drugs but the range of available drugs and of things that could be treated with new drugs increased, so that in spite of boards' efforts to contain costs through better efficiency, the overall cost of prescriptions was increasing, and often for good reasons.

We do not have any immediate plans to follow up that work, but we are keeping it in our sights. We are due to publish a report in late spring on hospital prescribing costs, which might shine more light on what is happening to drugs costs. I am afraid that we do not have any comparisons with the position elsewhere in the UK or further afield.

George Lyon: In your report, you present a case study of Greater Glasgow NHS Board, the opening paragraph of which states:

"Greater Glasgow NHS Board is currently projecting an in-year deficit of £4.2 million for 2004/05 and a balanced … position by the end of 2005/06. But the board has identified a funding gap of almost £59 million for 2004/05".

Can you explain why the position has gone from a projected in-year deficit of £4.2 million to a gap of nearly £60 million? There is a huge difference between the two figures. What is the reason behind it?

Angela Cullen: The board identified a funding gap of £59 million, but through work that it plans to do, savings that it plans to make, other initiatives and the receipt of other non-recurring money from the Health Department, it expects to reduce the deficit to £4.2 million by the end of the year.

George Lyon: So it was identified at the beginning of the financial year.

Angela Cullen: Yes. The £59 million is a gap, but the board has identified around £54 million of money that it will get from elsewhere to reduce the deficit to £4.2 million.

George Lyon: Do you believe that that is achievable?

Angela Cullen: You are putting me on the spot. The figures are for the year 2004-05. The auditors have not done sufficient work to comment at this time.

Mr Black: I am sure that members of the committee will appreciate that it is not our role to second-guess management.

George Lyon: I just asked for an opinion.

Mr Black: The board has laid out the information in the financial plan.

One of the purposes underlying the case study on page 18 was to highlight the general areas in which the board is attempting to bridge the gap and get the deficit down. I would like to think that the exhibit highlights clearly the extent to which the board is relying on non-recurring income and expenditure to get itself back into balance. Given the figures, the board will still find its cost base under huge pressure in future years.

Susan Deacon: I seek clarification on pension costs, which you mention in your summary report. I could be wrong, but I do not recall you placing quite so much emphasis on pension costs in the past. Will you elaborate on that, with particular reference to the debate in the press over the past day or two about proposed changes to NHS pension arrangements and how those might or might not impact on the NHS in Scotland?

Mr Black: It is not an area that we have examined in detail, but since it is very much an issue for the health service—as it is for all public bodies—we thought it right to put in a paragraph or two on that issue around page 21. You will see that the estimate of the additional cost to NHS bodies of the increase in employers' contributions is at least £226 million. As we understand it, that is the amount that would apply to the whole of Scotland, and it is a real cost to the NHS in Scotland. Our general understanding is that the department will make money available to health boards to cover that cost, but it is definitely an extra burden on the NHS going forward.

Mr Welsh: The figures are estimates—a look at the future. How confident are you that the basis of those estimates is accurate? Are you satisfied that the fundamentals on which they are based—such as cost data, performance information and information systems throughout NHS Scotland—are sufficiently robust to allow us to have confidence in them?

Mr Black: We obtained the in-year figures and projected figures from auditors, but they are board figures and they are not audited. There is always a caveat with regard to in-year figures and projections, but to have an understanding of the health service's overall financial position, we require to report on what is happening in the current year and what the service's forward plans look like.

Mr Welsh: Are the individual NHS boards' estimates and management information absolutely robust throughout the country?

Mr Black: I could not give the committee that guarantee. There are examples in the report of areas in which we feel that there are real risks, not least the one about which we talked: the different perceptions of the actual cost of the GMS contract. There are also differences between the views of the Health Department and of the health boards on the impact of the emerging financial burdens.

The Convener: That concludes committee members' questions on the briefing. I remind the committee that we will have the opportunity to discuss our concerns and our reaction to the report under item 7.

"The 2003/04 Audit of Argyll and Clyde Health Board"

10:01

The Convener: Item 4 is the second evidence-taking session examining the Auditor General for Scotland's section 22 report on Argyll and Clyde NHS Board's accounts.

I welcome our witnesses to the Audit Committee. Today, we have with us the former accountable officer of the Scottish Executive Health Department and chief executive of NHS Scotland, Mr Trevor Jones. He is accompanied by Mr John Aldridge, who is the former director of performance management and finance at the Health Department.

Before I ask the witnesses to introduce themselves and make an opening statement—if they wish to—I will make a couple of points. First, I state that Trevor Jones is here willingly. He has not, as was reported on one radio station today, been compelled to come but is clearly pleased to be here to help the committee in its deliberations.

I apologise for the background noise, which I hope is being attended to.

I reiterate, for the benefit of the public and the press, my comments from the previous evidence session setting out the focus of our evidence session today. The Audit Committee considers and reports on a variety of financial documents, including reports from the Auditor General. That remit carves out a distinctive role for the committee in that we hold to account those who spend public funds to ensure that they do so effectively and efficiently. In this instance, the committee is to examine the financial and wider management practice at Argyll and Clyde NHS Board and the way in which the Scottish Executive Health Department supports and monitors the performance of that health board.

I emphasise the fact that the remit of the Audit Committee is to examine financial, not policy, issues. I ask members to bear that in mind and I give fair warning that questions that, in my view, fall outwith that remit will be ruled out of order, although the committee has been good so far.

Our questions today will focus on the role that the Health Department played in monitoring and supporting NHS Argyll and Clyde's financial position. I should stress that Trevor Jones is here not to represent the department's views, but to help us to find out what informed his view when decisions were taken when he was the accountable officer. That should help us to establish some of the past practice, before we

take evidence at a later date from representatives of the Health Department.

With that explanation of why you are here, Mr Jones, I invite you to make any opening remarks that you may have before we start our questions.

Mr Trevor Jones (Former Head of Scottish Executive Health Department and Chief Executive of NHS Scotland): Thank you, convener. I do not wish to make any opening remarks apart from referring to your own introductory remarks, in which you kindly pointed out that I was not forced to come before the committee. I understand that another point that was made in the radio programme to which you referred was that this was the first time that anyone had come from England to give evidence to the committee. That is wrong too, as my predecessor attended the Audit Committee while working in England. Other than that, I understand that the report was accurate.

The Convener: Very good. Thank you for that. I will start the questions. I wish to begin on the role of the Health Department in developing a financial recovery plan. In accountability review letters since 2001-02, the department has asked for revised financial recovery plans. Did the department receive all the financial recovery plans that it requested from NHS Argyll and Clyde? Further, how did the department assess those plans that it did receive? What criteria did you use? In your view, were the plans robust?

Mr Jones: To put the financial recovery plans into context, it is worth standing back and thinking about what the responsibility of NHS boards and other public sector bodies is. There is an absolute, underlying requirement on public sector bodies to live within the resources that are allocated to them by the Scottish Executive.

There is a duty on accountable officers to ensure that action is taken by boards to deliver those financial duties. If boards are not prepared to do that, accountable officers have a duty to raise the issue with the Auditor General and, eventually, the Audit Committee. As an accountable officer myself, I had such a responsibility if I did not think that action was being taken. The bottom line is that any organisation must live within its resources. There is no ability to spend cash that is not there—that could be only at the expense of other organisations in the NHS system. That is the background to requiring boards to live within their financial positions.

I became accountable officer in October 2000. Up to that point, Argyll and Clyde Health Board had a reputation for delivering on its financial duties. However, there was growing concern in the department that the board was delivering those financial responsibilities using a high level of non-recurring funding. Targets were delivered, but only just and not on a recurring basis. You will notice from my first accountability review with Argyll and Clyde Health Board—from the letters that you have already seen—the point that I raised with the then chairman, Malcolm Jones, about the need for a sustainable financial plan. That plan was intended not simply to deliver on financial duties, which Malcolm Jones was doing; it was to be a sustainable plan on a recurring basis. That is the message that we were putting to the health board in the 2000-01 accountability review.

To move on to the mid-year accountability review in 2001-02, you will notice from the letter to the new chairman of the board that we were concerned that the forecast had changed by then, from being in balance to being in deficit, while there was still not a financial plan. We had been promised a financial plan in the first accountability review. That was not delivered—it was not prepared. The board was then forecasting a deficit. The position was getting worse.

That position has continued and the financial position of the board has been worsening. After the old team resigned and the new team went in, we were clear that the critical thing was to have a robust financial plan delivered sufficiently promptly to prevent cumulative deficits from rising and reaching a level from which it would be impossible to recover. The financial plan that I was looking for was one that had the board in balance in year. Such a plan had to be developed quickly, to ensure that the board could recover the cash that had been spent over and above the resources that Parliament had allocated to it. There were two parts to the plan: sustainable recovery and in-year balance; and the recovery of cash that had been spent inappropriately. I never saw a financial plan that could deliver that, which is why no recovery plan was signed off while I was the accountable officer for the NHS. It would not have been appropriate for me to have signed off a financial plan that would not have delivered financial balance in year and that could not demonstrate the recovery of cash that a board had spent for which there had been no Scottish Executive funding. I requested a plan that delivered what we were seeking and every year's accountability review from 2000 sought that position. Up to the time when I left the Health Department, I had not seen such a plan.

The Convener: I seek clarification. You said that plans did not deliver recovery in year. What would have been your approach to a plan to deliver recovery over three or five years?

Mr Jones: In 2002-03, we saw a draft plan for recovery over a five-year period, which contained no plans to recover the cumulative deficit that would have resulted from such an approach. In my

experience in the NHS, plans that deliver savings in years 4 and 5 cannot be relied on. I suspect that the world would have changed so much by the time year 4 was reached that there would have been huge risks in the final years of the plan. I stressed to the board that we needed to see recovery before year 5 and that it was critical that urgent action be taken.

We were not asking the impossible. Boards elsewhere in Scotland were in similar positions to that of Argyll and Clyde NHS Board. Committee members will recall well that Tayside Health Board faced a similar position. A new team was appointed and prompt, urgent action was taken. Financial recovery was achieved very quickly and the board then moved into development mode. Another example is Lanarkshire NHS Board, which this year forecast significant deficits in year in the current year and significant cumulative deficits. The Health Department had frank discussions with that board, which reacted promptly and turned the position round in about six weeks. The board produced a plan that delivered in-year balance in the current year, but required support to handle the cumulative deficit. I have been out of touch with the position for four months, but I understand that Lanarkshire NHS Board will break even this year. The board has moved from having an in-year deficit of about £20 million to securing financial balance in year, by taking very prompt and clear action. That is what I was seeking from Argyll and Clyde NHS Board. There was a need for determination urgently to achieve recovery so that the board would not accumulate a deficit, because obviously if deficits are allowed to rise to a certain level, they become impossible to recover, which was the situation that we were trying to prevent.

The Convener: We might seek further clarification on your comments when we discuss the failure to agree a financial recovery plan.

What dialogue did the Health Department have with Argyll and Clyde NHS Board about risks and about the sensitivity of plans to change?

Mr Jones: There was on-going dialogue with the board. My colleague John Aldridge might comment on that, because he managed the detailed discussions with the board. The board's directorate of finance and performance management was in regular contact. We had escalated our intervention in the board and there were monthly meetings about the financial position. John Aldridge might comment on the detail of our intervention.

I will talk more generally about the levels of support that the Health Department provides to NHS boards. The first level is the provision of funding to boards to address financial pressures. Wherever possible, the department ensures that such funding goes to all boards, because all NHS boards face financial pressures. I recall three very significant investments in NHS boards over the period that the committee is considering. In 2001-02, the then Minister for Health and Community Care allocated £90 million to NHS boards with the proviso that they must address any underlying deficits. In 2003-04, we allocated an extra £30 million of non-recurring funding to assist with financial pressures, principally pay pressures. In the current year, the department restricted its own central funding proposals severely to release £67 million to NHS boards to relieve pressures.

10:15

The first level of support by the department is the provision of non-recurring funding to address pressures. The department could no doubt supply the committee with other figures, but the three figures that I quoted are ones that I recall. The second level is support from the corporate NHS. We have regular meetings with the chairs and chief executives of NHS boards and the committee will not be surprised to hear that the financial situation appears on the agendas. Those meetings are used to share information on the financial position throughout Scotland, but also to share information on the action that different boards take to address problems. The department encourages any NHS board that is in difficulty to work with boards that are successfully addressing the problem and sorting out the issues.

At the June meeting of NHS boards, we had a frank discussion about the financial situation of the NHS in the current year. At that time, the overspend that was forecast for the current year was probably due to the problems with accumulated deficits in Argyll and Clyde and Lanarkshire. We discussed whether individual boards should be expected to find their own savings—that is, whether boards that were overspending should make savings or whether the sum should be shared among all NHS boards in Scotland by the application of an efficiency saving to recover the forecast overspends. A clear view came from that meeting that boards that successfully manage their financial situation should not be expected to find additional savings to bail out boards that overspend. We had that debate with corporate NHS Scotland and I must say that a firm conclusion came from the meeting that it is not appropriate to impose a levy on successful boards to fund deficits elsewhere.

The third element of support is direct support that is provided by the department to individual boards. John Aldridge will describe the process that was running with Argyll and Clyde during the period.

The Convener: Before I bring in John Aldridge, it might be worth while if I ask my question. We understand from the evidence that was provided by NHS Argyll and Clyde that some 22 meetings have been held. Over what period were those meetings held and what action did the department take as a result?

Mr John Aldridge (Scottish Executive Finance and Central Services Department): By way of background, when we brought together the Health Department's performance management and finance functions in 2001, that was a deliberate decision to ensure that the risks of the service delivery aspects of the work and the financial aspects of boards' activity were considered together and in the round rather than in separate silos, which had been a risk in the department in the period before that.

As a result, when the situation arose in Argyll and Clyde and the NHS board needed more intensive assistance and help from the department, we ensured that there were meetings approximately monthly—sometimes they were held more frequently and sometimes they might have been six-weekly—at which officials from both the performance management side of the department and the finance side met colleagues in the board to discuss progress with its plans to ensure that robust services continued to be provided in Argyll and Clyde and to ensure that financial recovery was pursued.

I gave that background to indicate the way in which we tried to ensure that the risks associated with financial recovery were fully taken into account. It was not a question simply of our finance staff speaking to finance staff in NHS Argyll and Clyde and requiring the balancing of the books no matter what the cost. Rather, it was a case of taking an holistic view of the activity of NHS Argyll and Clyde and seeking to ensure that the financial recovery plan took account of the need to continue to provide services at an appropriate level and took account of the various risks that we knew were on the horizon when I was in post, such as the new pay contracts, which were still under negotiation.

The meetings were part of a continuous process. It was not a question of having a meeting to decide what one action the department would then go away and carry out. Rather, there was a process of continuous meetings on an approximately monthly basis. The process sought to ensure that NHS Argyll and Clyde had the information and support that it required from the department—in terms of short-term financial and organisational support—and from other parts of the NHS. For example, my colleagues at the meetings would draw on their experience of activity elsewhere in the NHS in Scotland and would indicate to NHS Argyll and Clyde where they might be able to approach another health board that had faced a similar difficulty in the past.

We sought to take account of the risks and help NHS Argyll and Clyde to deal with the risks by drawing on experience from elsewhere. Where necessary, we discussed with colleagues whether there was any action that we could take within the department.

The Convener: Before I hand over to Margaret Jamieson, I would like to clarify one point with Trevor Jones.

I fully understand your concerns about five-year plans and the reliability of looking even four years hence. From things such as the consultant contract and the GMS contract, we can see the difficulties and risks that are involved. However, are you saying that proposals that involve a timescale of two or three years are not reliable enough? Do they have to be within a one-year period?

Mr Jones: I am not saying that they have to be within one year; I am saying that, for me to have confidence in the delivery of plans, I need to see an acceptance of the need to deliver financial duties, a firm commitment to address the problems, people working with colleagues elsewhere in the NHS in order to learn from their experience and urgent action being taken to ensure that boards are not building up an underlying deficit while they are thinking about the longer term—it is important that people work in the short term and the long term. There is no simple formula for the assessment of a position; one simply has to see the commitment, drive and action on the ground. Those of you who were close to the Tayside recovery will have seen the commitment and drive at the front end of the process that lay at the heart of its success. I felt that we never had that commitment in the last recovery plan that I saw from Argyll and Clyde.

The Convener: A number of other members are interested in that point, but I will bring Margaret Jamieson in first as we are starting to delve into issues that she was going to cover.

Margaret Jamieson (Kilmarnock and Loudoun) (Lab): I want to ask about the failure of the department and NHS Argyll and Clyde to agree the financial recovery plan. From the evidence, I note that the department took note of the board's financial recovery plans from 2001 on but never agreed or approved them. Why has that not happened thus far?

Mr Jones: I repeat what I have just said. It would have been inappropriate for me, as the accountable officer, to authorise boards to spend cash that had not been allocated to them when there was no firm plan to ensure that they would

fulfil their financial duties. I have never seen a financial recovery plan that would have Argyll and Clyde NHS Board fulfilling its financial duties and living within the resources that have been allocated by the Scottish Executive. Accountable officers are not able to spend money that they do not have.

Margaret Jamieson: Okay, that is fine. However, the board continued to spend beyond the allocated budget. In the accountability review letters that have been provided to us, that view is not made as explicit as you are making it today. Can you tell us why that is the case?

Mr Jones: I do not agree with what you have just said. I recall making an explicit statement about not accepting the recovery plan. In the letter of August 2003, I stated:

"We made it clear that we could not support the financial plan as it stood."

I cannot think of a sentence that could be more explicit than that. I went on to say:

"I made it clear that we would expect the Board to maximise non-clinical savings and any savings from redesigning services to provide better care for Argyll and Clyde residents before reducing clinical services. You and your team made it clear, and I accepted, that the Board is determined to tackle the financial challenges facing Argyll and Clyde."

We can fight over what words are in the letters, but I know that what was said at the meeting could not have been more explicit. I think that that letter is clear as well.

Margaret Jamieson: You are talking about 2003, but the situation has been on-going since 2000. It was only in that letter that your position became explicit.

Mr Jones: I remind the committee that, in the run-up to 2000, the board was fulfilling its financial duties, but we nevertheless raised the concern that there was an underlying deficit. It must also be remembered that, in the run-up to 2000, the measure of management was on cash, not on income and expenditure. We were concerned that there was an underlying deficit that needed to be addressed. Therefore, in my first year as accountable officer, I asked the board for—and was promised—a financial recovery plan. We did not receive one in that first year. The board then went into deficit and we again sought a recovery plan. To the point at which I ceased to be an accountable officer, there was never a recovery plan with which I felt comfortable, for the reasons that I have described.

Margaret Jamieson: You are saying that, as the accountable officer, even when you were about to leave, you were still not comfortable with the recovery plan.

Mr Jones: Yes.

Margaret Jamieson: How do you measure the risk to which the Health Department was exposed by the board being unable to satisfy you and your officers?

Mr Jones: My role was not to manage the individual boards—to use the Auditor General's phrase, which I like, I was not there to second-guess board management. My role was to ensure that NHS Scotland was fulfilling its financial duties.

As I said to you, we were having monthly discussions with NHS board chief executives and chairs about the financial situation of NHS Scotland. I will give an example from June, although you would find similar discussions at every meeting. On 28 June, there was a full and frank discussion about the financial situation of NHS Scotland. I said to the NHS board chairs that, at that time, the NHS was forecasting that it would overspend by £102 million in the current financial year of 2004-05 and that, as the accountable officer, I found that unacceptable. As the accountable officer, I could not authorise the boards spending £102 million that we did not have, which was equivalent to 2 per cent of the budget. I said that the £102 million shortfall should be addressed either by individual boards that were overspending or by NHS Scotland taking a corporate view. The outcome of the meeting was that it would be inappropriate to levy a charge on boards that were successfully managing their resources to support those that were overspending.

10:30

My requirement as the accountable officer for the department was for the NHS in Scotland to break even. At that point, there were only two options. The department had cut back on central programmes in order to issue £67 million from central funding to support the NHS. After we had done that from the centre, our only option was to ensure that the resource was well managed across all the boards. Either all boards contributed to the deficit, which would mean imposing a levy of £102 million across 15 boards, or the boards that were overspending pulled back their expenditure. As the minutes of the meeting show, the very firm view was that it was inappropriate to expect boards that were currently in balance to make further savings. We agreed that boards should continue to look at ways of reducing projected deficits and plan to achieve in-year balance. As the accountable officer, I took that action. I had discussions with chief executives and chairs throughout Scotland to ensure that NHS Scotland remained in balance. I must say that, historically, NHS Scotland as a corporate organisation has had a very strong record in financial management.

Indeed, that view is always reflected in the Auditor General's reports.

Margaret Jamieson: You obviously had concerns about the financial management of Argyll and Clyde. After all, an expert support team was put in to try to restore financial propriety. Why did you not draw a line at that stage? After the team went in, Mr Campbell was appointed chief executive.

Mr Jones: Could you elaborate on the phrase "draw a line"? At that point, the board was living within its resources and delivering its financial targets. What action do you suggest that we might have taken to draw a line under the matter?

Margaret Jamieson: That is not the information that we have received.

Mr Jones: In 2000-01, when a cash management system was in operation, the board was very close to meeting its cash target. I do not have the figures in front of me, but I recall a cash overspend of about £700,000, which means that it was within £700,000 of living within its resource of £500 million. In 2001-02, when we moved to a resource accounting system, the deficit was £1.3 million out of £500 million. The board was almost—but not quite—in balance. In December 2002, the old team left. In March 2003, at the end of the financial year 2002-03, the deficit was £9.6 million. I simply seek clarification about the action that you would have expected us to take in order to draw a line. Would you have expected us to underwrite the board's deficit or the recurrent deficit? I am not sure what you mean by drawing a line.

Margaret Jamieson: We have heard that you asked the expert support team to go into Argyll and Clyde because you had concerns. Indeed, the minister himself replaced individuals. My point is that Mr Campbell was appointed as the accountable officer to move things forward and to ensure that the board regained financial control. You are now saying that there was a small financial overdraft. Why was that not treated separately from the new moneys that are now coming to the surface?

Mr Jones: You have raised an interesting point. Should the—

Margaret Jamieson: I am not saying that the deficit should be written off.

Mr Jones: No, but you have raised an interesting question. When a chief executive in an organisation changes, should the financial history, whatever that might be, be written off? You might say that; I do not think that that tactic would be sensible, nor would it encourage good financial management in the public sector. A chief executive does not have sole responsibility for the financial position of their organisation. The NHS board as a whole is responsible for the organisation's management.

Margaret Jamieson: What if the chief executive becomes the accountable officer?

Mr Jones: The chief executive is in a very difficult position. That is why, if an organisation takes decisions that an accountable officer considers inappropriate, that officer has the safety valve of referring upwards. That is needed. If a board outvotes an accountable officer on financial propriety issues, the officer needs cover.

I noticed that you nodded when I said that it would not be appropriate for any Executive department to clear actual deficits incurred or unfunded recurrent deficits every time that a chief executive changed. Boards need to take responsibility for living within the resources that are allocated to them.

The real issue to which we are moving is deciding at what point a situation becomes unmanageable. I just took figures from the outturn of the Argyll and Clyde organisation, under which recurrent deficits will exist. Before we came to the table, the committee discussed Greater Glasgow NHS Board, which forecasts a £60 million deficit. The reality is that it will sort most of that before the year end. If the chief executive in Glasgow had changed at the start of the year, when it forecast a deficit of £59 million, it would not have been bright of the Health Department to clear that £59 million and find that Glasgow had a significant surplus at the year end.

The issue was how much support the new team needed to manage its resources. We have described the support that was going into Argyll and Clyde. I have said clearly that my view was that the first draft of the financial plan would never have brought the board into financial recovery. It would have made savings too far in the future and it did not address the cumulative underspending. That is why, in the first accountability review with the new management team, which took place in August 2003, we were clear about the expectation. I expected a new recovery plan that produced savings earlier, which would prevent the board from accumulating a deficit at a level from which it could never recover. That is the plan that I never saw.

Interestingly, the situation became stark when I read the evidence that the committee received just before Christmas, in which the board stated clearly that it was not prepared to provide another financial plan. The clear statement in the *Official Report* of that committee meeting perhaps describes the difference between the accountable officer locally and the accountable officer at the centre. The statement was:

"What we have not been prepared to do … is to change the basis on which the recovery plan was designed."—[*Official Report*, *Audit Committee*, 21 December 2004; c 886.]

That is the first time that I have seen such a stark comment.

I have said consistently that the original financial recovery plan was not delivering savings fast enough to prevent a large deficit. I read from a transcript of the board's comments to the committee and it sounds as if the board was saying that it was not prepared to change that plan—the committee will know whether that was the board's intention. That has been the dilemma for two years.

Margaret Jamieson: I ask for clarification. The ministerial support group was appointed in December 2002.

Mr Jones: The chief executives left in December 2002. If I am not mistaken, it was October when the support group went in.

Margaret Jamieson: So that happened in 2002 and within the financial year 2002-03. Do you accept that Argyll and Clyde NHS Board reported an in-year deficit of £9.6 million when the new chief executive took over?

Mr Aldridge: I recall that the forecast deficit changed during that period. When the support team went in, the forecast deficit for the year was about £5 million.

Margaret Jamieson: In December 2002?

Mr Aldridge: By December the forecast figure was about £9.6 million—I cannot remember precisely, but it was thereabouts. The interesting conclusion is that, despite the arrival of the new management team, the figure did not change over the rest of the financial year.

Margaret Jamieson: I have just one further point of clarification. What actions or suggestions were provided to NHS Argyll and Clyde in order for the board to convert from what it saw as a 5-year recovery plan to your stated requirement for a 3-year recovery plan?

Mr Jones: I refer the member to the accountability review letter from which I quoted—I will not do so again. In the letter, I suggested that what was needed was to take a rigorous look at non-clinical areas and drive inefficiencies out before moving on to look at clinical areas. There was an absolute need to review the whole of the cost base and to take urgent action.

I return to the position of NHS Lanarkshire. In about May 2004, a similar discussion was held with that board following its forecast of a significant deficit in 2004-05. The chairman of NHS Lanarkshire grasped its finances very tightly and cleared the in-year deficit by a range of measures. I do not have the detail of those measures, but the committee could arrange to get them from the Health Department or from the board.

There is evidence that when a board has a major financial problem, the key to success is to take urgent action. That gives the board time to put in place a long-term sustainable solution.

Margaret Jamieson: Of Argyll and Clyde's cost bases, only two—maternity and older people's services—were above the Scottish average. All other services were below average, including acute services.

Mr Jones: I do not know if those figures are right or wrong. I do not have that information in front of me.

The Convener: That questioning has generated a number of supplementaries. A number of members—including George Lyon, Andrew Welsh and Susan Deacon—are indicating that they would like to come in at this point. If their question is covered by the questions that Mary Mulligan is about to put, I ask them to leave the issues to her. With that caveat, I call George Lyon.

George Lyon: I have a point of clarification. You argued cogently that the previous team in Argyll and Clyde was delivering financial balance. The question therefore arises of why you put in a hit team, sacked four chief executives and replaced them with an interim team, only to refuse to accept the financial position that the independent team identified and put to the department? You refused to accept their figures and yet, as they were not running the board at the time, no vested interest was involved. Given your argument that the four chief executives were doing a good job in achieving financial balance, why did you sack them?

Mr Jones: It might seem pedantic, but there was no hit team; a support team was put into Argyll and Clyde. No chief executives were sacked by me, as the department cannot sack chief executives. In fact, none of the chief executives was sacked. It is important for the record that that is understood. That was not the situation.

The support team was put into Argyll and Clyde for a range of reasons. I can speak only from the position as at October 2000. The papers that I was sent for the meeting included the previous accountable officer's accountability review letter, which includes a sentence that said that the accountable officer was pleased that relationships within Argyll and Clyde had improved—I think that was the phrase that was used. The statement implies that, prior to that time, there had been a problem with those relationships.

My position with Argyll and Clyde commences with the 2000-01 financial year. At that time, we had meetings with the chairs and chief executives of all the NHS organisations in Argyll and Clyde about their financial situation and their 2000-01 outturn. The meetings were held through November, December and January. My difficulty was that, whenever I met the group, I could not get a consistent position from them on their financial position. Each organisation had a different view—

George Lyon: So, that begs the question—

10:45

Mr Jones: I am sorry—could I answer the question?

I was concerned about the lack of a consistent view among the group. I was even more concerned about the open conflict amongst members of the group: the group was not working as a cohesive team.

We also had difficulty with the level of delayed discharges in Argyll and Clyde. We had a separate support team that was working with any board in Scotland that had problems with delayed discharges. That support team went into Argyll and Clyde to look at the issue of delayed discharges. That would probably have been around March to May of 2001, although I do not have the precise dates. That support team was reporting concerns about how the NHS system was working in Argyll and Clyde and about its poor relationship with the local authorities. I was concerned about the relationships among the senior team—the chairs and chief executives—and we had concerns based on the support team report about the relationships with the local authorities.

We then moved into 2002-03, when I described the financial situation as worsening from a position where the board was delivering its financial targets, but only with non-recurrent plans, to a situation where the board was now forecasting real deficits. We had moved to a situation where the financial position was getting worse. I continued to have discussions with the chairs and chief executives, and it became clear that that group could not work well together. There was one particular meeting in my office where the eight individuals met me and there were literally arguments across the table about what the issues and problems were and whose fault it was. It was at that point—

George Lyon: Are you referring to financial issues?

Mr Jones: No. The issues were about the way the board was working. Again, the accountability review letter refers to concern about how the senior team was working. On delayed discharge, for example, there was lack of respect for each other's position and lack of understanding of the different roles. Generally, the relationships of that key leadership group were giving me major concern. It was at that point that I raised the particular level of concern with ministers, and ministers decided to put in a support team. It was not simply about the financial situation; it was about the ability of the then senior team to work as a group that could lead the NHS in Argyll and Clyde out of the very difficult challenges that it faced. All NHS boards have major challenges, and Argyll and Clyde have some specific ones. I was losing faith that that group of individuals would be able to bring the board through to success. We put the support team in then, and as the support team was reporting, the four chief executives resigned. That is the history.

George Lyon: It is a funny coincidence, is it not? Did you accept, then—

The Convener: John Aldridge wishes to add to that.

Mr Aldridge: You indicated that you thought that we were refusing to accept the financial figures that the support group—

George Lyon: I did not say that. Mr Neil Campbell said that in his evidence to this committee.

Mr Aldridge: Right. I think that I would say that we had no disagreement with the figures that the support team produced on the financial position in Argyll and Clyde. In fact, that was a welcome clarification of the underlying financial position.

George Lyon: Did you accept that figure, then?

Mr Aldridge: We had no difficulty with accepting that there was an underlying deficit of around £30 million or thereabouts in the system at that time. What we have taken issue with since then are the speed with which, and the ways in which Argyll and Clyde NHS Board is going about tackling that figure.

George Lyon: I shall quote what Mr Neil Campbell said in evidence to this committee. He said:

"Over the two years and 22 meetings, we have gone through a cycle of discussions, which began by a lack of agreement about the starting position for Argyll and Clyde."—[*Official Report, Audit Committee*, 21 December 2004; c 900.]

Those are his words, not mine. You are contradicting that view.

Mr Aldridge: Well, as far as we are concerned, we entirely accepted the figure that the support team produced as being the underlying deficit. What we disagreed with were the ways in which

and the rapidity with which Argyll and Clyde NHS Board was tackling that.

Mr Jones: The issue is not what the figure was. The issue is that organisations have to live within the resources that they have, and they need to take action to address that. It was the lack of prompt action to reduce the level of overspending that was at issue. Irrespective of whether that deficit was £30 million, £29 million or £32 million, there needed to be action to address it.

Your quotation said that there had been 22 meetings, and I have more than that on my schedule of meetings. There were an awful lot of meetings going on, but they were not about debating the deficit; they were discussing what action would be taken to sort it out. Prompt action was required to reduce the level of expenditure. The level of deficit is almost immaterial; what was necessary was action on the ground to reduce expenditure.

If we look at the data, it is interesting to note that the number of staff employed in the Argyll and Clyde system has increased in every year since 2000. That will not produce an answer. If that trend continues, we will never get financial recovery. If NHS boards are overspending, what I expect is action to reduce their expenditure. That is what we wanted, not debate about what the figure was.

George Lyon: I hear what you say.

I have one further question. On a number of occasions, you have referred to NHS Lanarkshire as being the model that you would have expected NHS Argyll and Clyde to follow. It is clear from the Auditor General's figures that NHS Lanarkshire has plugged the gap by using non-recurring funds, which Neil Campbell described as smoke and mirrors. If NHS Argyll and Clyde had produced a plan that was based on the extensive use of non-recurring funds, would you have accepted that?

Mr Jones: No.

George Lyon: Why did you accept NHS Lanarkshire's plan, which was predicated precisely on that basis?

Mr Jones: Let me say again that I have not said that NHS Lanarkshire is the model.

George Lyon: I am sorry, but that is what you said.

The Convener: Let us hear the answer.

Mr Jones: I said that what I need to see is drive and commitment by organisations to address their problems. I cited two examples of boards that have displayed their commitment to solving financial problems. I mentioned NHS Tayside and NHS Lanarkshire. I was not holding them up as models; I was simply saying that there is evidence that it is possible to recover quickly from financial problems. In the short term—until a board could get to a more stable position in the longer term—one would expect solutions to involve the use of non-recurrent funds.

It is interesting that, as I understand it, the section 22 report shows that Argyll and Clyde is using the same level of non-recurrent solutions that it was in 2000-01. In the current year, Argyll and Clyde's financial position is that about £15 million to £20 million still comes from non-recurrent sources. I notice that the auditor is saying that the real deficit in Argyll and Clyde is £15 million more because of the amount of non-recurrent funds that are being used by the board.

There is nothing wrong with NHS boards using non-recurrent solutions. I have had a debate about that with the committee on several occasions. I have no problem with boards using non-recurrent solutions to financial problems, as long as that supports a recovery plan that gets boards into a position of financial balance. Our concern about Argyll and Clyde was that even though it was in such a position, it had got there only because it had used non-recurrent measures; it did not have a sustainable recovery plan. My view is that it is necessary to have a sustainable plan. I have no problem with a board using non-recurrent support in the short term to allow it to get to a sustainable position, but I would have major concerns about a board that did not have a recovery plan—in other words, a board that was using non-recurrent measures even though it had no plans to live within its in-year resources or to recover cumulative deficits.

Mr Welsh: You have just outlined the problems. What practical solutions did you give the board to solve those problems?

Mr Jones: I described the additional funding that went into the NHS and the process through which corporate NHS Scotland provided support. I recall a meeting of chief executives at which we asked boards to give presentations on how they were managing their financial situations, so that other boards could learn from that. John Aldridge described the support that the department was providing to encourage the board and to drive it forward.

Mr Welsh: I suggest that although that approach addresses the superficial problem, it denies the underlying fundamental issues. Will you clarify how and when the department became aware that there were serious in-built financial and auditing problems in Argyll and Clyde NHS Board?

Mr Jones: I am not sure what auditing problems you are talking about.

Mr Welsh: I asked for how long you had known about them, but it is obvious that you do not know

about them. Argyll and Clyde NHS Board inherited problems from its predecessors such as Argyll and Bute NHS Trust and Lomond and Argyll Primary Care NHS Trust. For example, audit reports show that by 1999 there had been breakdowns in the control environment and in the provision of effective management information and that there was insufficient evidence on the existence of £1.1 million of tangible fixed assets. Those misrepresentations of the financial position were passed on. Did you know about those inherited problems? What did you do about them?

Mr Jones: I was aware of the financial position—the income and expenditure financial position—of the board and the accumulative position of the board when I became the accountable officer in 2000. I cannot comment on what happened in 1999, as I was not in the Executive then. However, from October 2000, I was aware of the financial position of Argyll and Clyde NHS Board. In every accountability review letter, you will find me saying that what is required in Argyll and Clyde is a financial recovery plan that will allow the board to live within the resources that are allocated to it by the Scottish Executive. That message could not have been made any clearer.

Mr Welsh: But if there was a breakdown in effective management information—

Mr Jones: In 1999—is that what you said?

Mr Welsh: As far as I am aware, such breakdowns have continued and the problems have continued. Are you telling me that there is accurate, effective management information throughout the whole system? That is not the impression that I have from the evidence that we have received. Can you assure us that there is absolute financial control right now?

Mr Jones: That is a question for the accountable officer.

The Convener: Andrew, we must have questions about the past that are relevant to the period when Trevor Jones was the accountable officer.

Mr Welsh: I simply ask this: how could Argyll and Clyde NHS Board—in your words—accelerate its financial recovery plans if its fundamental management information for 2000 was inaccurate?

Mr Jones: I am looking for action, not analysis. Cash can be saved by making services more efficient, by reducing the cost of non-clinical support services or, if necessary, by reducing clinical services. It is not about management information; it is about taking action to reduce expenditure. That is the thrust—action. We need to see action to reduce cost and improve efficiency. Let us be crude: we need to see fewer people employed. That is the reality for the NHS.

Mr Welsh: I am with you on efficiency.

Mr Jones: Yet, over the whole period, according to the published data, staff numbers have been increasing in Argyll and Clyde.

Mr Welsh: To manage accurately, one has to know what one is managing in detail.

Mr Jones: Yes.

Mr Welsh: The problems require practical help, but you seem to have offered an holistic view, monthly meetings, encouragement and funding. Do you accept that the Health Department looked at the symptoms rather than the underlying problems?

Mr Jones: No, I would say exactly the opposite. I was not looking for analysis of the problem; I was looking for solutions. It is interesting that you say that we should have provided practical help. I have described what we did. Can you give me a feel for what you think we should have done? We could have a debate around whether we did or why we did not, if we did not.

Mr Welsh: Mr Jones, you were managing—you were in charge, not me. I am just saying that you were offering an holistic view, monthly meetings, encouragement and suggestions for best practice, although it looks as though there were more fundamental problems to address.

Mr Jones: Argyll and Clyde NHS Board was managing health services in Argyll and Clyde; I had no management responsibility. I could not control the board's expenditure: that is not a relationship.

Mr Welsh: Absolutely, but—

The Convener: Let us move on to Susan Deacon's supplementary question.

Susan Deacon: I have a specific question about the process in relation to the 22 meetings that, by common agreement, took place between the beginning of 2003 and the end of 2004. The information that has been provided to us by the Health Department gives a breakdown of when those meetings took place and the attendance at them. There was some consistency in the attendance from Argyll and Clyde NHS Board—specifically, Neil Campbell and James Hobson pretty much attended all the meetings. However, there was not the same consistency in the attendance of the Health Department—in fact, 13 people from the department took part in the meetings over the period. Did that lack of consistency and continuity on the part of the department militate against reaching a solution to the situation? If different people were attending the

discussions, how could one expect conclusions to be reached?

I note that the cost of attending those various meetings, both in financial terms and in terms of senior management time, is not inconsiderable, particularly given that the meetings involved the board's top team, which was composed of the very people who were charged with the task of resolving the problem. With hindsight, could any practical improvements have been made to the way in which the department interacted with senior managers in trying to take forward those discussions and, ultimately, in reaching those conclusions?

11:00

Mr Jones: Hindsight is a wonderful thing. Looking back, we should perhaps have taken firmer action earlier to ensure that the financial plan came in. Had we done so, we would not have been sitting this far on without agreement. The question is whether different messages came from the department, but I do not think that that happened. I do not have the minutes in front of me, but I suspect that there were few departmental board meetings—meetings that are attended by all directors in the Health Department—at which we did not discuss the Argyll and Clyde situation. John Aldridge was closer to those meetings, so he may be able to confirm this, but I would hope that the department sent a consistent message about our expectations. I have nothing that leads me to suspect that different messages were sent out. I am not sure that the end result would have been affected whether the department had sent 13 different people or two people.

There was a fairly simple problem. I do not believe that any plan produced savings early enough to allow the board to avoid creating a huge cumulative deficit. That is my position. I do not mean to quote Neil Campbell inappropriately, but the *Official Report* of this committee's previous meeting shows that the board's position was that it was not prepared to change the first draft—he uses the word "basis"—of its financial plan. I was unaware that that was Neil Campbell's position until I read the *Official Report*, but if the issue was as simple as that, that is probably why we are where we are now.

We have now reached the position that I tried to avoid, which is that the board has a very significant cumulative deficit. That cumulative deficit exists now because action was not taken earlier. I guess that the only way in which we could have closed that down would have been to have taken more rigorous action earlier. That must be the answer.

Susan Deacon: The huge question is how we break this impasse, as the situation still has not been resolved. Frankly, it should not require a full parliamentary committee inquiry following on from a report from the Auditor General before the former chief executive of NHS Scotland and the chief executive of a local NHS board develop a mutual understanding. You will appreciate that there is some frustration round the table on this matter.

Mr Jones: I share that frustration. That frustration is very clear—at least, it is clear to me—in the minutes of the meeting that I had with the NHS boards in June. We cannot have a situation in which a small number of boards overspend and do not have plans to clear that overspend.

As far as I am concerned, there are only three things that we could do about that. First, the Scottish Executive could allocate more funding for health, but there are huge reasons why that would not provide an incentive to good financial management. Secondly, boards that are living within their resources could give up some of their resources to support those that are overspending. That would keep the system in balance and the problem would go away. Thirdly, boards that are spending more than their fair share could be expected to make the savings. Those are the three options.

I presented two of those options in stark terms to all the NHS boards in Scotland. I told them that either those boards that are overspending must manage their resources, or those that are in surplus or breaking even must contribute money to the corporate pot. The view of that meeting was that it was inappropriate to penalise those boards that are managing. We need to accept—perhaps everyone does not—that the department had already emptied its coffers by reducing its programmes by £67 million and issuing that money to the service before we got to that £102 million position.

The choice is stark: we either reduce the funding for all boards in Scotland to clear deficits or we expect the boards that incur the deficits to make changes locally. I cannot see another way, but John Aldridge might—I may be missing something.

The Convener: Mary Mulligan will now ask her questions. We have a number of points to get over and I suspect that there will be some supplementary questions. I am keen that we stick rigidly to getting the questions over. Because of the background din, it is important that all questions and supplementaries go through the chair, otherwise it will be difficult to conduct the meeting.

Mrs Mary Mulligan (Linlithgow) (Lab): If I may, I will begin with a question on what Mr Jones has just said, which relates to the question that I was going to ask. He made a great deal of the meeting of the board chairs and the discussion about whether those boards that were on budget should release additional funds to those that were not. The committee has tried several times to find another health board to which to compare Argyll and Clyde NHS Board to help to find the cause of the problems that that board is experiencing, but we have not been successful in that. Is there something significant about the make-up or design of Argyll and Clyde NHS Board that has led to its problems and that means that, as you said, it cannot respond to problems in the way that boards such as those in Lanarkshire or Glasgow have done?

Mr Jones: That is a difficult question. I guess that, first, Argyll and Clyde is not a natural community; it feels as though it is what was left after all the other boards had been set up. It is difficult to see a relationship between Oban and Paisley, because they do not form a natural community. Such a situation will not necessarily create financial pressures, but it may contribute to them. Secondly, historical relationships within the NHS system and with other key partners in the public sector were not as strong there as they were elsewhere in Scotland. Such a situation makes financial management harder, so it may have contributed. Other than those two points, I cannot think of anything particular about Argyll and Clyde.

Mrs Mulligan: I just wanted to give you the chance to clear up that issue.

My next question is about savings plans. You said that you were not happy with the savings plan that was produced. What factors does the department take into account in deciding whether a savings plan is realistic and robust and whether it has faith in it?

Mr Aldridge: I will mention some of the criteria that we look for, although Trevor Jones has mentioned one or two of them already. One is sustainability; the plan must not simply provide a short-term fix, but must last into the future. Another factor is, as I mentioned, the speed at which financial recovery is to be achieved and the ability to avoid a cumulative deficit building up, which would cause a problem in the future. A third factor is the extent to which the savings are deliverable and will continue to provide good health services in the area. Trevor Jones has already referred to that crucial point. In the accountability review letters, we said that the first port of call should be the support and non-clinical services and that clinical services should be at the end of the queue. Those are three of the key criteria.

Mrs Mulligan: Mr Jones said that he accepts that non-recurring funding could be used in the short term to assist health boards while they are developing more sustainable proposals for the longer term. Does the department have a view on the proportion of savings that the board could make from recurring or non-recurring sources?

Mr Aldridge: I am not sure whether you are looking for a general position or the position of Argyll and Clyde now, which I cannot give, as I no longer work in the Health Department. In general, it is a question of horses for courses. The situation depends on the seriousness of a board's financial difficulties and the availability of non-recurrent resources. Some boards have more capacity than others to generate non-recurrent receipts, for example. If boards know that such receipts are coming, they can be forecast reasonably accurately and built into plans. Other boards have exhausted or are close to exhausting their capacity to generate those receipts, so it would be less appropriate for them to rely on undeliverable non-recurrent receipts.

Mrs Mulligan: You mentioned the seriousness of the position in which a board found itself. Does the situation that Argyll and Clyde is in suggest that some leeway should be given over timing? I accept that, once a recovery plan goes five years into the future, it becomes uncertain and therefore difficult for you to accept, but did Argyll and Clyde's situation influence your decision?

Mr Aldridge: The situation influenced our decision to the extent that we accepted that it was impossible for Argyll and Clyde to return to recurrent balance within a year, which is what we normally look for in a recovery plan. The five years that the NHS board's plan suggested was the time that it would take to get back into balance seemed too risky and too long.

Mr Welsh: How much did the department know about the use of non-recurrent money? Did it do anything about that?

Mr Aldridge: We knew each year how much of the resources that were being spent in any health board was non-recurrent and recurrent. The NHS board's job each year is to balance the books—to break even, taking one year with another. Obviously, we know the extent to which the books are balanced by the use of non-recurrent resources. What do we do about that? If we become concerned—as we did in the case of Argyll and Clyde in 2002—that the reliance on non-recurrent resources is too great, in the sense that the risk is that those non-recurrent resources will cease to exist in future and the board will be left with a recurrent underlying deficit that it cannot meet, we take action, as we did in the case of Argyll and Clyde.

Mr Jones: If we had decided that it was inappropriate to use non-recurrent funding and stopped the board doing that, that would have brought forward to an even earlier point the need for action to reduce the recurrent spend. Based on the information that had been presented, I said that recurrent savings needed to be made earlier. If we had not allowed the board to use non-recurrent funding—the £15 million or so that it is using this year—it would have had to make those recurrent savings even earlier than I was looking for them to be made. That would have made the task even bigger.

Mr Welsh: Did you ever consider the use of non-recurrent money a problem? How closely did you monitor it?

Mr Jones: We monitored the situation monthly. It is interesting that one committee member has said that almost too many meetings were held and asked what the cost of all the meetings was. We had rigorous monitoring because of the size of the problem. More monitoring is not the answer, however; the answer is action to reduce the expenditure base.

Mr Welsh: That is agreed. More meetings were probably not the answer. How did you monitor ring-fenced money?

11:15

Mr Aldridge: There are different kinds of ring fencing. In some cases, money is allocated for a particular purpose and the precise amount of resources allocated for that purpose must be spent on that service or item. With other kinds of ring-fenced resources, an amount of money is issued to health boards, often by a formula, and they are given a target for what they must deliver. If they can deliver that level of service without using all the ring-fenced resources, they can sometimes reuse some of those resources for other purposes. Equally, if they cannot deliver the service for the resources that they have been allocated, they have to find extra resources from their general allocation.

I will give a typical example of how we monitor the expenditure on ring-fenced services. We would ask every health board to provide a plan of how it was going to spend the resources and, when that plan ought to have been completed, we would expect a report from the board on how the resources had been spent.

Mr Welsh: So you would get regular reports. If funds were not spent for the purpose for which they were allocated, did you consider it your duty or responsibility to report that to the minister? Was that ever a problem?

Mr Aldridge: If resources are not spent for the purpose concerned, that would be a matter for the auditors to identify and it would come to the minister's attention in due course.

The Convener: Before we consider departmental support to Argyll and Clyde NHS Board, I have a question for Trevor Jones. Talking about the need for earlier action, you used the phrase "rigorous action" a number of times. You also drew attention to the fact that the staff complement had been increasing year on year. When you talk about rigorous action, do you mean slower staff growth than there was, a freeze on staff growth or a staff reduction?

Mr Jones: If a health board with a budget of £500 million spends £35 million more than it is allocated, it needs to employ fewer staff. In the NHS, 70 per cent of costs are staff costs. The reality, difficult though it is, is that it is impossible to have increasing staff and recover a recurring deficit of £35 million.

Margaret Jamieson: We were advised that a number of staff were identified as surplus to Argyll and Clyde's requirements but were on secondment to the Health Department and continued to remain there, even though the costs of employing them were still being met by Argyll and Clyde. If the Health Department required individuals to undertake specific work, would it not have been appropriate for it to pay for them and thereby alleviate some of the pressures on Argyll and Clyde?

Mr Jones: I am not sure what the example is. If I had the detail, I could answer the question. If anyone was working on a specific Scottish Executive initiative for a significant period of time, we would normally pay for them.

Margaret Jamieson: What would a significant period of time be?

Mr Jones: If someone comes into the department for six months to do a piece of work, I would expect the department to pay for them. A significant number of staff in the department are seconded from the NHS, but the department and the central expenditure programmes meet the cost. I am not sure what the specific example to which you refer is.

Margaret Jamieson: The example concerned staff who were identified as surplus under the new management regime.

Mr Jones: That might be different. I am speculating, but if we are talking about staff whom Argyll and Clyde no longer needed, but did not want to—

Margaret Jamieson: One of them was one of the former chief executives.

Mr Jones: I do not recall one of the former chief executives of Argyll and Clyde working in the Health Department since leaving the health board. If they did, it was not to my knowledge.

If we second staff—if we have a specific piece of work that we want to do and we bring staff into the department to do it—the department pays for those staff. If anybody was in the department on the basis that you describe, I would be surprised if that made a significant dent in the size of the deficit anyway. I guess that we are dancing on a pinhead in terms of impact on the deficit.

Margaret Jamieson: That issue was raised.

The Convener: If it is a material fact, we can gain more evidence on it and make that available to you and John Aldridge to seek clarification.

Robin Harper (Lothians) (Green): We understand that the department provided Argyll and Clyde NHS Board with verbal assurances that it would receive enough cash to meet the costs of its in-year operational activities up to 2007-08. Why did you not provide it with a written assurance?

Mr Jones: I am not sure how that would have addressed the financial deficit. I am trying to understand how material that is in terms of an organisation taking action to live within its resources. I do not know the detail of the issue. John Aldridge might have more information.

Robin Harper: We simply find it difficult to understand that the board was given only a verbal assurance, rather than a written one.

Mr Aldridge: I am not sure whether there is any particular inwardness in that. However, as Trevor Jones has indicated, there is a strong argument that it would be inappropriate for the accountable officer of the NHS in Scotland formally to endorse a board overspending.

Robin Harper: Trevor Jones has indicated that on two occasions already this morning. Did the department provide the board with assurances about the cumulative deficit? If not, did you have discussions with the board about how the cumulative deficit would be recovered?

Mr Jones: My view is always that the first thing a board should do is avoid accumulating a deficit—it should take action to avoid doing so. A deficit is important and serious. It represents expenditure being incurred in excess of the cash allocated. It is a breach of financial duties. Responsibility for that lies with the organisation that is incurring the deficit. I was rather surprised to see in the *Official Report* the board suggesting that a deficit is an accounting issue. A deficit is not an accounting issue. A deficit is real expenditure in excess of allocated resources. It is a serious issue.

The only way in which the department could clear a deficit would be by taking funds that would otherwise go to the other 14 boards and using that money on the board with the deficit. We did that for Tayside. A sum of £90 million was brought forward from the previous year. The decision by ministers was that that £90 million should be allocated across the service, but that the first charge against it must be to clear deficits. Within that, we allocated Tayside more than its fair share, to recognise the action taken by the new management team to put the board back on its feet. The support for the deficit in Tayside came after the difficult decisions had been taken by the board to put itself back into recurring balance.

I suspect—this may be inappropriate, because I am a non-accountable officer—that if Argyll and Clyde had got itself back into in-year balance, we would have had a discussion around the cumulative deficit, which would have been significantly less than it is now.

Robin Harper: I presume that in your discussions you reiterated the view that you have given us, which is that the major way to recovery is through staff reductions. However, you have indicated that the reality is that staff numbers have increased year on year over the past four years. Would you like to comment further?

Mr Jones: Staff would not be the only issue. In terms of the order of decisions, the first thing one would consider is non-clinical, non-staff costs. One would then think about efficiency in terms of clinical services, particularly around non-staff costs. After that, one would be thinking about the non-clinical support staff. A reduction in clinical services would be the final area that any NHS organisation would go into. However, when deficits are being run at such a level, the assumption must be that the board is providing clinical services that it cannot afford and that action must be taken to address that matter.

I recognise the difficult position that Argyll and Clyde NHS Board was in and the political situation in that area, which perhaps made it much more difficult for the board to take the difficult decisions that were needed to get it back into balance. I return to the 2000-01 position. I remember that, when the Argyll and Clyde Acute Hospitals NHS Trust tried to take difficult clinical decisions about services, it simply could not sustain those decisions because of the pressure that it was under in the environment in which it was working.

George Lyon: You have stated—we have received evidence to this effect—that there has been no letter of comfort from the department to the health board about the board's current position. However, you have provided verbal assurances that the board will continue to be underwritten in respect of the cash that it needs to

operate services. Who is accountable for that? What controls are there on that cash? You have clearly stated that you had no confidence in and did not accept the starting figure, and you do not accept the recovery plan that the board put forward, which seems to indicate that you have no confidence that it can recover the situation. However, cash continues to be provided. What is the status of that cash? How is it accounted for?

Mr Jones: I have not said that I did not accept the starting figure—I do not know where that statement came from. John Aldridge has clearly explained that we were not debating the size of the problem; rather, we were looking for savings. For the *Official Report*, I have not said—

George Lyon: So you accepted the starting figure.

Mr Jones: We have said that we did not query the starting figure. We have said on several occasions that we wanted to see action for recovery. It is important that I correct what you have just said; I did not say that I gave verbal assurances.

George Lyon: It has been alleged that the only reason why the Auditor General and one of his auditors signed off the accounts last year was that your department gave a verbal assurance about the cash position vis-à-vis the board, or else there would have been a section 22 report on the health board.

Mr Jones: I have not said that this morning. I want to be clear about what I have said this morning.

George Lyon: I was referring to when you were the accountable officer for the area.

Mr Jones: That is okay.

We must be pragmatic and consider the reality of the situation. We were trying to get a firm recovery plan from the board to allow it to provide the right level of high-class health services to its population—the department is still trying to do that. We have not tried to make things difficult. We have tried to get the board to make the necessary decisions so that it can provide services within its resources. There would be no advantage in the department taking action that would increase pressure on the board from an audit perspective. The department is saying that it will not pull the plug and stop cheques being issued—that would not take anybody anywhere. Equally, it is important to say that the department is not going to give a message to the board to the effect that overspending is acceptable. An issue is involved that we need to understand.

George Lyon: I appreciate that, but you have mentioned on two previous occasions £90 million and about £60 million—I think—being handed out to boards.

Mr Jones: The figures are £67 million for this year, £30 million for last year and £90 million in 2001-02.

George Lyon: That money was directed at overspends. Has the signal always been that you will plug the gap?

Mr Jones: Should we not assume non-recurrent funding for services?

George Lyon: I am simply asking about the signal.

11:30

Mr Jones: The signal is clear. If the department can generate a non-recurrent reserve, we issue it to all boards on an equitable basis to allow them to improve health services.

A board that is spending more than it has got does not have the ability to use the extra cash to spend on extra services; it must use the cash to clear the deficit. The allocation letter in relation to the £90 million could not have been more specific on that point. The service received a one-off benefit of £90 million, because an underspend was brought forward. Boards that were managing resources well received a proportion of the £90 million to improve services. Boards that were not managing resources would derive no benefit from the £90 million, apart from a reduction in the deficit. That is good financial management. The reverse would have been true if the £90 million had been allocated only to boards that were in deficit, because that would have offered an incentive to everybody in the NHS to overspend. As the accountable officer, I thought that that would have been quite inappropriate. We should not do anything that gives boards the impression that it is acceptable to spend more than they have been allocated or to push back difficult decisions. All boards face huge challenges and most boards manage those challenges remarkably well in difficult circumstances.

George Lyon: You have said repeatedly that you wanted to see action from the management team—

Mr Jones: We wanted action from the board. The board is responsible.

George Lyon: The management team, which draws up the plans, is also responsible. In the first year after the team took over, £13.5 million of savings were made. Bigger savings were planned for the current year; for example, the board is making redundant or not filling 180 posts, and is closing wards throughout my constituency and other constituencies. How much more action did

you want to be taken? The board seems to be making a genuine attempt to cut recurring costs; it is not using smoke-and-mirrors methods.

Mr Jones: The section 22 report on the financial position indicates that of the £13 million savings, only £6.8 million—half the figure that you quote—represented recurrent savings.

George Lyon: The situation in relation to support for Lanarkshire NHS Board was not much different.

Mr Jones: If Lanarkshire is living within its resources and has strong management, that is fine. The first point is this: what is needed to get Argyll and Clyde NHS Board back into balance is a recurring reduction in expenditure of £35 million, based on the board's position at the start of the process. Based on the section 22 report, the recurrent deficit that the auditor for Argyll and Clyde quoted is £50 million. For Argyll and Clyde NHS Board to be in recurrent balance, either the board must reduce expenditure recurrently by between £35 million and £50 million or the Executive must increase its allocation to the board by the same amount.

George Lyon: The board could use non-recurring funding, as other boards do.

Mr Jones: I am not setting out what I want; I am setting out the requirement for NHS bodies in Scotland. I am now in an NHS body. We are all required to live within the resources that are allocated to us; such is the accountable officer's duty. Boards must either get more income from the Scottish Executive, which can come only from other NHS boards or Executive programmes, or they must reduce their expenditure. That is not what I require, as accountable officer; it is the requirement of the Executive and the Scottish Parliament through the democratic process.

George Lyon: You wanted bigger savings to be made in the first two years.

Mr Jones: No—I am saying that for a board to deliver its duty, such savings must be delivered. That is the requirement.

George Lyon: But for you to sign off on the financial recovery plan, there must be savings—

Mr Jones: Yes, absolutely—

George Lyon: That was what I was asking.

Mr Jones: For me to sign the recovery plan—

George Lyon: You wanted bigger savings to be made in years 1 and 2.

Mr Jones: Yes—and earlier.

Susan Deacon: A great deal of what you have covered this morning—indeed, many of your responses to George Lyon's questions—gets to the heart of the relationship between the Health Department and boards in general as well as Argyll and Clyde NHS Board in particular. I will ask some general questions about the relationship, but first I want to ask about the specifics of the relationship with Argyll and Clyde NHS Board. How effective has the Health Department's support to the board been? Before or after the expert management team was sent in, did you discuss and explore with the board the Health Department's role and the support that the board needed? How satisfied are you that the Health Department now knows whether its support function is effective in meeting the board's needs?

Mr Jones: As you will understand, I cannot talk about what the relationship is like now.

Susan Deacon: Describe the most recent situation that you can.

Mr Jones: The position that we are in now says that the relationship was not as effective as it needed to be, as we have not solved the problem. That has to be the position; I accept that. What were relationships like? In my view, we had a remarkably close relationship with the individuals in Argyll and Clyde NHS Board. Certainly, throughout the period from when the delayed discharge task force went into Argyll and Clyde through to when the change was made to the management structure, I spent a huge amount of time working with the board's chair and the four chairs who were there at the time, but especially with the board chair and chief executive, trying to find solutions before the minister sent the support team in. However, we failed. I do not regard it as being a success that people resigned; I think that it represents a failure of the system when that happens.

I felt that there was a close working relationship. We have listed formally meetings at which there were all sorts of contact over and above the norm. We had regular discussions and made regular telephone calls, although it is clear that the chief executive does not feel that he had the support that he wanted. Neil Campbell and I came to Scotland at about the same time. We worked together as board chief executives for a long time. We knew each other well enough to say whether the relationship was not working, but we did not have any such discussions. The reality is that he faced a difficult task and, although a huge amount of other things are going on in Argyll and Clyde that are fine, we did not agree on the recovery plan. There was tension, but that is all.

Could we have done it differently? Of course we could. One should always learn from processes. I do not have a simple answer to the question. If we had known what should have been done, we would have done it.

Susan Deacon: Although hindsight is not a perfect science—I have heard it suggested that it is a spurious vantage point—you now have the luxury not only of being able to look back and reflect but, given that you are no longer working for and with the Scottish Executive, of being able to have, one might think, a degree of freedom of thought and speech in the process, which might enable you to help the committee to get to the bottom of how the body politic in Scotland can get better at resolving such apparently intractable situations in certain parts of the NHS. Any learning that you could share with us in that regard would be welcome.

Mr Jones: It is a hugely complex issue. I know that you will not welcome this, but I can now reflect on how the English system works, as I have four months' experience of that system.

My organisation is in surplus, but the area in which I work and which I have to performance manage had the biggest deficit in England two years ago. It faces huge recovery plans. One thing that makes it easier for chief executives in England is that there is less political focus on NHS bodies. In Scotland, there is intense political focus on them and it is hugely difficult for any NHS organisation in Scotland to change an existing service, irrespective of the quality of that service and its ability to pay for it. Any manager in the NHS will have a view about the configuration of services in Argyll and Clyde and what needs to happen, but getting support to make those changes is hugely difficult. Neil Campbell covered some of that towards the end of his evidence, when he talked about the political goldfish bowl in which he works. The process in England feels more managerial.

I am 104 miles from Westminster, from where it is easier to handle some of the issues. There is a dimension in respect of the intensity of the job, which feels different, and there are other issues on which I will reflect as I fly back.

Susan Deacon: I welcome your sharing that thought, which is important for us to consider in our discussions. Notwithstanding that observation and despite the fact—which you have just identified—that there are strong personal relationships and relatively high degrees of trust between accountable officers, it has still proved to be remarkably difficult not just to reach agreement and resolution on a financial recovery plan, but to reach a common understanding of some of the underlying problems. Those issues are not a product of the political environment. Is there something else that we need to consider? Does either the structure of, or practice surrounding, the relationship between the Health Department and the health boards need to be changed to expedite solutions to problems such as those that we are discussing? I say with utmost sincerity that your personal perspective on this is extremely valuable, not least because you have worked for a major board in the NHS in Scotland post devolution, so you have seen life from both ends of the telescope, which only a relatively small number of individuals have done.

Mr Jones: I will come to the substance of the question, which is important, but I want first to say that I do not think that there is disagreement about the source of the problem. That is not the issue; the issue is how we find a solution. I did not disagree with the board on that.

Is there a fundamental structural difference? It is fair to say that there was a significant change—such as I did not see when were making the changes to the unified board—in that we were removing local discussion in respect of some of the issues. Historically, the NHS board and trusts would have had difficult discussions about how to get the system in balance; such local discussions would have taken place 15 times throughout Scotland. The move to the unified board, which is the right structure for Scotland—there is no doubt that it is the most efficient way to manage health services—has added significantly to the department's task of managing the service, because it does not have the 15 agents of the NHS boards who historically undertook that performance management function. That is a different dynamic and I guess that it takes time to bed down.

Susan Deacon: I am conscious of the time. Irrespective of the specific structure of the health service in Scotland, there will require to be interface between the Scottish Executive Health Department and local NHS bodies—let us use that generic term. Whose job is it ultimately to thrash out resolution on problems? Are we dealing with fundamental ambiguities of responsibility that need to be resolved?

Mr Jones: I would have seen it as being my job as chief executive of the NHS to ensure that the NHS was providing services with the resources that it has. To do that, we have to ensure that all the constituent organisations are doing that. There is no question that there has been buck passing. It is absolutely the role of the centre to find resolutions, but the structure is not such that services are managed directly from the centre. We have separate statutory organisations that have statutory responsibilities to deliver within that. It is much more about how we work with organisations to get them to deliver their duties, rather than our instructing them from the centre. The matter is not about command and control. That would not be the right way to manage the service. We must accept that if we create separate statutory

organisations, the responsibility lies with the board.

11:45

I keep saying "the board". There is a danger that this will become an issue for the chief executive of NHS Scotland or chief executives of NHS anywhere, but the relationship is not like that. It is about boards taking responsibility for living within their resources and providing the best possible health service. However, there is an unofficial relationship. There is no line of accountability between NHS board chief executives and the chief executive of the NHS, but there is a relationship in that the NHS chief executive is in daily contact with board chief executives. We tried to develop a relationship—I will not comment on whether it worked—whereby the chief executives' group managed the NHS corporately. In January last year, we introduced the chief executives' business meeting, which took over many of the old Health Department's functions. Rather than have six directors in the Health Department decide how the service should be managed, we had those debates with departmental directors and all the chief executives in the NHS to try to develop a stronger corporate feel. I think that the seeds of that were working quite well, although there is still a long way to go. We must accept that the formal relationship is from the board to the Executive—the board to ministers. I do not think that to have a direct line of accountability through to the chief executive of the NHS would be the right thing to do. Some people argue that it would, but I do not agree.

The Convener: That answer and Susan Deacon's previous questions lead me to a supplementary that I will ask before I bring in George Lyon. What options are open to the Health Department when it deems a financial plan to be unacceptable? Is there an additional power that you, as an accountable officer, would have liked to have had at your disposal?

Mr Aldridge: I will respond first.

A number of steps can be taken; there is escalating intervention. We start by trying to encourage improvement and we ask for revised plans and so on. If that does not work we can escalate to having regular meetings that involve more senior officials at board and departmental level. If that does not work, the ultimate sanction is to send in someone to do the work for the board—we send in a commissioner or an agent from another board. That is a new power that was taken recently in legislation. That plugged a gap. Until that gap was plugged by the legislation the next stage was, in effect, to bring about a change of personnel in the board. Two or three years ago there was probably a gap in our armoury, but that ought to have been filled. We have still to see how the new legislative power works.

The Convener: Would that power have been helpful to Trevor Jones? I am not saying that you would have had to use it.

Mr Jones: One of the lessons that we learned through the events in 2001-02 in Argyll and Clyde was that the support team went into Argyll and Clyde without any official power—it had no legislative backing. We had concerns about personnel—the chief executives decided to leave. If a chief executive did not leave and if there was felt to be a need to dismiss that person, that could not have been imposed by the department and at the time it could not have been imposed by the NHS board. Individual decisions would have been required by individual trusts, which is why in the National Health Service Reform (Scotland) Act 2004 we provided for removal of management of certain services from NHS boards if they were not being doing so appropriately. That strengthened the position.

Generally the system works remarkably well and we do not have problems. The NHS is well managed, according to the Auditor General's report—there is good financial management and the NHS is sound. We are dealing with an exceptional situation. I always think that we have to be wary of putting in new processes to deal with an exception when the system generally works well. In spite of the pressures, the NHS is delivering.

George Lyon: I have a more general question that is not specifically on Argyll and Clyde, but which has come up in a number of evidence sessions on the NHS. My question is about the consultant contract and what the benefits of it might or might not be to the NHS in Scotland. What are the benefits of the consultant contract in terms of performance and activity levels in the NHS in Scotland?

Mr Jones: That is an issue for the accountable officer.

The Convener: That is a fair answer.

I thank Trevor Jones and John Aldridge for the evidence that they have given us today and for putting up with the background noise and with the foreground noise from members. Their evidence has been most helpful. As usual, we might seek clarification of a number of points later. For example, it might be useful for us to see evidence of the information that was available on the growth of employment figures. I imagine that Mr Aldridge might be able to help us with that. If we need any further written evidence we will be in touch.

11:51

Meeting suspended.

12:03

On resuming—

"Better equipped to care?"

The Convener: We are quorate, so rather than wait for other members to get back—I am sure that they are on their way—I will press on.

Agenda item 5 is on medical equipment. The committee will consider a response from the Scottish Executive to the committee's ninth report of 2004 on "Better equipped to care? Follow-up report on managing medical equipment". I invite members to comment on the Executive's response, then I will invite the Auditor General to make any comments that he wants to make.

I add that we have looked into the possibility of moving rooms. There is some difficulty in doing so, but it might be possible to do so when we move into private session, although members might think that there will not really be much point by then.

We will keep going with item 5. I invite members to comment on the Executive's response.

George Lyon: On first reading, it appears that the department has responded positively to some of the issues that we raised. Indeed, I was quite pleased with the response—for a change. It is not often that we can say that about a response from the Health Department.

Mr Welsh: From phrases such as "active monitoring", "engagement with" certain people, "consideration of … resources" and

"continuing to take positive action"

and the reference to developing various matters, it strikes me that this is on-going business and that the issue might be subject to a further report. The actions highlighted in the response are at least a move in the right direction.

The Convener: Does the Auditor General have any comments to make?

Mr Black: Generally, we felt that the response was very positive. Barbara Hurst has gone through it carefully and is in a position to provide one or two more detailed comments.

Barbara Hurst: As the Auditor General has pointed out, we were quite pleased with the response, which we found to be very positive.

I have one point of clarification. In our original report, we referred to a controls assurance system in England that the department might have wanted to use as a model. That system has been abolished, although an assurance framework has been retained. Although the issue is not centrally monitored in the same way, the principle remains and we believe that it still applies to the system in Scotland.

The Convener: If members have no other comments, I ask the committee whether it is happy to note the Executive's response and content that no further action need be taken.

Members *indicated agreement*.

"Maintaining Scotland's roads"

12:06

The Convener: We move on to item 6, which is consideration of the Scottish Executive's response to the Auditor General's report "Maintaining Scotland's roads". Before I ask Audit Scotland representatives to comment, I invite comments from members.

Mr Welsh: The issue remains a massive problem for all Scotland's local authorities. I note that action is still being taken on certain matters, and I think that we will probably have to return to the subject.

George Lyon: The Enterprise, Transport and Lifelong Learning Department's response at least shows that it is taking steps to calculate the size of the structural maintenance backlog using commonly accepted methodology. I welcome that approach; after all, without an agreed position, it is difficult to have a debate about the size of the problem and whether it is being addressed.

I was quite confused—to put it mildly—by some of the response from the Convention of Scottish Local Authorities. First, it criticises the Scottish Executive—

The Convener: The COSLA paper is more for information. It is not really under discussion.

George Lyon: I will leave that paper for now and let other members in.

The Convener: The COSLA paper relates to community care, which is why it does not make a great deal of sense in relation to the report on roads.

George Lyon: I am sure that we agreed to write to COSLA on this matter.

The Convener: We discussed writing to it, but decided not to do so.

George Lyon: Sorry about that.

Margaret Jamieson: It is interesting that the Local Government and Transport Committee will take evidence from David Pia of Audit Scotland and the heads of the roads departments of various authorities in Scotland. Perhaps we should see what that committee will do with the report.

The Convener: That is a good point. Indeed, that is why we decided not to move forward with the report ourselves.

I invite the Auditor General or David Pia to make any further comments on the response.

Mr Black: I do not think that we have anything to add.

The Convener: In that case, is the committee happy to note the response?

Members *indicated agreement*.

The Convener: I thank David Pia for attending the meeting. After all, it is always better to be here.

That takes us to item 7, which we have agreed to take in private. I will give members of the press, the public and the official report the opportunity to vacate the room. I thank them for their time.

12:10

Meeting continued in private until 12:43.

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