AUDIT COMMITTEE

Friday 11 January 2008

Session 3

£5.00

Produced and published in Scotland on behalf of the Scottish Parliamentary Corporate Body by RR Donnelley.

CONTENTS

Friday 11 January 2008

AUDIT COMMITTEE
1st Meeting 2008, Session 3

CONVENER

Hugh Henry (Paisley South) (Lab)

DEPUTY CONVENER

Murdo Fraser (Mid Scotland and Fife) (Con)

COMMITTEE MEMBERS

*Claire Baker (Mid Scotland and Fife) (Lab)
*Willie Coffey (Kilmarnock and Loudoun) (SNP)
*George Foulkes (Lothians) (Lab)
Jim Hume (South of Scotland) (LD)
*Stuart McMillan (West of Scotland) (SNP)
*Andrew Welsh (Angus) (SNP)

COMMITTEE SUBSTITUTES

*Derek Brownlee (South of Scotland) (Con)
*James Kelly (Glasgow Rutherglen) (Lab)
Iain Smith (North East Fife) (LD)
Sandra White (Glasgow) (SNP)

*attended

THE FOLLOWING ALSO ATTENDED:

Alasdair Allan (Western Isles) (SNP)

THE FOLLOWING GAVE EVIDENCE:

Ronnie Cleland
Mr John Angus Mackay (Western Isles NHS Board)
Donald Macleod
Paul Martin (Scottish Government Health Workforce Directorate)
Ken Matthews (Unison)
Alex Smith (Scottish Government Health Finance Directorate)
Mr John Turner (Western Isles NHS Board)
Kevin Woods (Scottish Government Health and NHS Scotland)
Malcolm Wright

CLERK TO THE COMMITTEE

Tracey Reilly

SENIOR ASSISTANT CLERK

Joanna Hardy

ASSISTANT CLERK

Rebecca Lamb

LOCATION

Comhairle nan Eilean Siar Chamber, Stornoway

Scottish Parliament

Audit Committee

Friday 11 January 2008

[THE TEMPORARY CONVENER *opened the meeting at 10:01*]

The Temporary Convener (Andrew Welsh): Fàilte oirbh uile ach, tha mi duilich, chan eil a' Ghàidhlig agam. Welcome everyone. I am sorry that I do not speak Gaelic—the language of the garden of Eden—but I bid everybody a warm welcome to the first meeting in 2008 of the Scottish Parliament's Audit Committee.

The committee's role is to hold to account individuals and organisations that spend public money, and to establish whether that is being done efficiently and effectively. The committee does not concern itself with the rights and wrongs of Government policy; rather, it concerns itself only with whether policy has been implemented in a way that secures best value for the public purse.

Today, we shall talk to past and present members of Western Isles NHS Board in order to gain more information about issues that have been raised by the Auditor General for Scotland in his report on the board's 2006-07 accounts.

I thank members of the public for coming to the meeting and welcome representatives of the media, who will film parts of the meeting. I remind everyone to switch off their mobile phones and pagers, please.

We have received apologies from the convener and deputy convener of the committee—Hugh Henry and Murdo Fraser respectively—and Jim Hume. I welcome James Kelly, who will substitute for Hugh Henry, and Derek Brownlee, who will substitute for Murdo Fraser.

Interests

10:02

The Temporary Convener: Agenda item 1 is a declaration of interests. In accordance with section 3 of the code of conduct, I invite Derek Brownlee to declare any interests that are relevant to the Audit Committee's remit.

Derek Brownlee (South of Scotland) (Con): I draw attention to my entry in the register of members' interests, although I do not think that it would be classed as relevant to the committee's work. I am a member of the Institute of Chartered Accountants of Scotland.

The Temporary Convener: Thank you. The clerks will note that.

Section 22 Report

"The 2006/07 audit of Western Isles Health Board"

10:03

The Temporary Convener: We now turn to our main business. The committee will take evidence for its inquiry into the section 22 report, "The 2006-07 audit of Western Isles Health Board".

I will explain the procedure. Evidence will be taken from four panels of witnesses, the first of which is now in front of us. We want to allow the maximum time for witnesses to be questioned and for them to respond fully to questions, but questions and answers should be short so that we make the best use of the available time. This is not a one-off meeting that will be the end of the matter; rather, it is part of a wider process that will culminate in a committee report that will be placed before Parliament. I remind everybody that this is not a public meeting; it is a formal meeting of the committee that is being held in public. That is important. Those who run national organisations are answerable to members of the Scottish Parliament, and their actions are openly scrutinised by the Audit Committee, to which they are accountable. That is at the heart of our democratic system.

I welcome panel 1. Ronnie Cleland is a former interim chairperson, and Malcolm Wright is a former interim chief executive, of NHS Western Isles. Mr Cleland has said that he does not wish to make an opening statement. Does Malcolm Wright wish to do so?

Malcolm Wright: Yes. Thank you, convener.

I was asked by the former Minister for Health and Community Care, Andy Kerr, and Kevin Woods to lead an interim support team for NHS Western Isles. The deputy chief medical officer, Peter Donnelly, and the director of nursing for Dumfries and Galloway, Gordon Jamieson, supported me in that endeavour.

The minister visited the Western Isles on 8 August 2006 and had a frank conversation with the board about his expectations in relation to its responsibilities for governance and proper management. We commenced our work on 14 August and completed it five months later on 25 January 2007 with the appointment of a new chair and new chief executive.

Our terms of reference were to support the interim chair and the board and to assess the situation with regard to patient services, corporate working, the board's financial sustainability and partnership working. We held more than 40 interviews with members of staff in the early weeks, had open staff meetings, talked about our organisations and conducted a high-level review of documentation.

I will briefly outline to the committee our main findings. We found that patient services were generally in a good condition, that there was an appropriate range of services, that the board was working towards its access targets, that hospitals were clean, that staff were trained and motivated and that strong primary care services and very good examples of good clinical practice existed—there were general practitioners with special interests, screening programmes were going well and there were a lot of good health improvement initiatives. However, we found that the main challenges that the board faced were in leadership, governance and management. We found a serious level of dysfunction in those areas.

There was a breakdown in relations between the board and some of its key staff, which had led to a vote of no confidence. There was no employee director as a member of the board, as there is, I think, on every other health board in Scotland. I think that the Western Isles had the poorest staff survey in the whole national health service in Scotland. The survey results had not been published by the time that we arrived, although just about every other health board had published its results.

Although the financial controls had improved with the appointment of a new finance director and two qualified accountants, we found that they still fell far short of what national recommendations and guidance required. The financial recovery plan was not adequate and, in many ways, fell far short of being sustainable and realistic, with large parts of it having no sound basis in action plans.

We found that the executive team had not been operating effectively and that a number of systems of basic management and control were not being put into place. Finally, we found that the board had not engaged properly in effective partnership working with Comhairle nan Eilean Siar.

We quickly came to the view that the health board's finances were in a serious condition and that the budgets had been overset by some £4.5 million, which was subsequently reported in an internal audit report. We came to the view that, without immediate action, the board was heading for a £1.7 million in-year deficit, so our immediate priority was to put in place control measures, and I would be happy to talk to the committee about the measures that we sought to put in place. We supplemented that action by commissioning a range of substantive and wide-ranging independent internal audit reports, and I would be happy to talk to the committee about those.

We focused our work on a number of key areas: the restoration of full partnership working with staff; setting up partnership working with the comhairle, particularly the establishment of the community care partnership—I think that the board was the only one in Scotland that had not adequately progressed such work; dealing with a number of grievances and disciplinary cases that required to be resolved; dealing with the financial recovery plan and moving the board towards financial balance; putting in place systematic clinical governance arrangements; the formation of a clinical strategy for the board, which I would be happy to talk about because it is key to the board's future sustainability; and ensuring adequate internal and external communications and adequate corporate governance arrangements.

In all, we found a very serious situation, but one that was capable of resolution with good leadership and strong management. The board faced and continues to face significant challenges, but there are also significant opportunities for it, particularly in joint working with the comhairle and community planning. There are also opportunities for it to work in clinical networks and managerial networks with other parts of the wider NHS in Scotland.

We finished our work on 25 January 2007 and handed it over to an incoming chair and chief executive.

The Temporary Convener: The committee will now look in detail at some of the points that you have raised under the headings of governance arrangements and systems of internal control, leadership and management, the financial recovery plan and performance management arrangements. James Kelly will start the questioning.

James Kelly (Glasgow Rutherglen) (Lab): In Malcolm Wright's opening statement, he acknowledged that there were weaknesses in governance. Will the witnesses give a bit more detail about the arrangements that they put in place to address the weaknesses in corporate governance specifically?

Ronnie Cleland: We quickly realised that the committees that were required to enable the health board to operate effectively by ensuring corporate governance were not doing that work. I am talking about the clinical governance committee, the staff governance committee and the patient involvement and public partnership committee. We were extremely concerned about the lack of functionality of those high-level committees, which every health board has.

Two levels of work were done with those committees. Because the committees are populated by non-executive board members, I took some time to discuss with each of the non-executive members their roles and inclinations, in the belief that people would make a stronger contribution in areas in which they were interested. That process went on over a period.

As well as making some changes in the composition of the board's committees, we undertook a programme in which we involved a number of people from Malcolm Wright's support team and brought in external people to visit the Western Isles, in order to provide clarity on the role of the committees, how they should work, the structure, the reporting relationships and where they fitted into the bigger picture of corporate governance responsibility. We encouraged people to take up roles of responsibility in an effort to ensure that clear programmes of work were delineated, action plans were in place and progress was made.

Malcolm Wright: I will add to that by giving some examples of areas of corporate governance that we did not think were adequate.

Part of the advantage of conducting such a wide range of interviews and discussions with staff was that a number of concerns emerged from that process. We commissioned the internal auditors, which are independent of the board, to produce a number of reports for us. One report covered the work of the remuneration committee and another covered the work of the endowment committee. The report on the remuneration committee found a number of weaknesses in control systems and audit trails in relation to how decisions were made, when meetings were held and the reporting of minutes back to the full board.

The endowment committee is a key committee of the board, given its responsibility for the stewardship of money that has been donated by people on the islands. We found that it had not met for some four years and that there were four years of annual accounts that needed to be signed off. Clearly, that is not an acceptable position. At the December 2006 board meeting, we reached the stage of re-establishing the endowment committee and having a first detailed look at the accounts, on which the auditors made a presentation. We finally signed off those accounts in January. Those are specific examples of areas in which things had gone wrong and improvements needed to be made.

The Temporary Convener: George Foulkes has a quick point to make.

George Foulkes (Lothians) (Lab): I have a supplementary question for Mr Wright. Although the deficit in 2005-06 was by far the largest, there were substantial deficits in 2003-04 and 2004-05. Why did it take so long for you to be appointed to

sort out the position? Were the problems allowed to run on for too long?

10:15

Malcolm Wright: I am not really in a position to make a judgment on that. The previous Minister for Health and Community Care was very concerned about the operation and corporate governance of the board. In the months leading up to his visit on 8 August 2006, he had made very clear to the board what it needed to do. We need to be clear about the responsibilities of Government and of the board. It seems to me that the board is a statutory body that is charged by Government and Parliament to fulfil its functions. We concluded that, although what we came across was very serious, there was nothing that could not be resolved by the board itself. In my view, the then minister recognised that. There was the visit in August 2006, and our coming in really helped to identify that.

George Foulkes: Do you not think that civil servants should have been telling the minister earlier that something needed to been done about Western Isles Health Board, rather than waiting for the 2005-06 deficit to emerge? It was, for comparison, about £500,000 in 2003-04 and £500,000 again in 2004-05. If you were head of the NHS in Scotland, would you not have said, "My goodness, something needs to be done about this"? Would you not be asking the minister to do something quickly?

Malcolm Wright: I am not head of the NHS in Scotland.

George Foulkes: We will see him later.

Malcolm Wright: I was asked to come in and do a particular job at a particular time. In coming in to do that job, I was aware that the Scottish Executive had offered a range of support to the health board in times past. I am sure that you will question subsequent panels on that. All I know is that I got a call and I was asked to come in. We found what we did, and the actions that I am able to describe are those that we took.

The Temporary Convener: You were walking into a deficit situation, which continued. What could you do about that?

Ronnie Cleland: I will start on that point, and I will then hand over to Malcolm Wright for the detail. You are absolutely right to say that we came into a deficit situation. Malcolm has already mentioned the various investigatory conversations that we held with a range of people and, as part of our initial work, we identified a number of areas where we felt there was room for improvement. In fact, I would be better to describe it as room for immediate action—and we took some immediate action. We had to arrest the deficit and its incline, and bring it back down. We brought a downward trend into the size of the deficit. Malcolm Wright will happily give you some examples of actions that were taken, if that would be helpful.

The Temporary Convener: In 2005-06, the deficit went up to £1.7 million. Then you got it down to half of that. However, that is still £880,000, compared with previous figures of £444,000 and £495,000. Clearly, that was a chronic situation.

Ronnie Cleland: You might want to use the phrase "run rate" in determining what we did. You are absolutely right—that was the nature of the beast that we came across. It was a difficult situation, with a load of problems. You asked what we could do about it. We can give you some clear examples of what we did about it immediately—upon arrival.

The Temporary Convener: What assistance was available to you to help solve the problems?

Malcolm Wright: We were able to call on whatever assistance we needed. We were able to call on colleagues from the Scottish Executive and from other health boards to come in and do specific bits of work for us. We quickly came to the eight areas that I outlined earlier and put a plan to the board around them. We were taking forward a range of actions.

The point about the run rate on the money is important. Having reasonably quickly concluded that the budgets were overset by £4.5 million—for an overall budget of £60 million, that is a very serious position—and having reached a projected overspend of £1.7 million in year, the immediate priority was to clamp the expenditure and control the cash that was going out the door. There were a number of things that we could do immediately.

I think that there were 52 order pads in NHS Western Isles—52 points where people were able to order things and commit the board to expenditure. We reduced that number to six. We also reduced to seven the number of people who could authorise expenditure and who had authority to sign things—that is, the directors and one or two senior people on the board. We controlled that quickly.

We put in place a vacancy review mechanism. Basically, we said that no post was to be filled until it had been through a mechanism. That process was not easy, but we tried to follow it in partnership with staff, taking into account clinical concerns and the financial situation. Certain posts were approved, but we said that we just could not afford to fill others.

We considered staff travel and control mechanisms for referral of patients to the

mainland. Most NHS boards would have such systems in place. We found that adequate systems were not in place, so we worked with colleagues on the board, particularly the director of public health and the medical director, to put them in place.

There was discussion of whether there was a plan for managing and controlling prescribing costs, but that was not an area that featured particularly strongly.

I could go on. We sought to do a number of things immediately to reduce the run rate of cash from the organisation. By the time we left, our best estimate was that there would be an £800,000 overspend. There were opportunities to pull that down further, depending on follow-through action.

The Temporary Convener: Although we are under time constraints, I am anxious to give you every opportunity to explain things fully. It is important that we hear the evidence.

Ronnie Cleland: I will give a short supplementary answer. You asked what resources were available to us. Our brief was to come here and do things. The quality of the people in the support team that I was given enabled me to feel comfortable that we could make decisions and take actions on the ground when we required to do so. It also gave me the freedom to reach out whenever I wanted to get support from within the Executive or from elsewhere in the NHS. We had a clear brief to sort things as best we could and create a stable situation for the people coming in. We needed to take action quickly and we were able to do so.

Alasdair Allan (Western Isles) (SNP): Welcome to the meeting. During your period as interim leaders of the board, was it part of your remit to produce a report for ministers about the overall situation in relation to governance and other aspects of the board's work?

Ronnie Cleland: Our remit was not to produce a report. As I have said, our remit was to do what we could to sort things and produce as stable a situation as possible for the incoming chair and chief executive.

Alasdair Allan: So, you were not asked to report to ministers on the situation in the board in any drawn-together, substantive way.

Ronnie Cleland: We were not asked to produce a report, but we were clear that, according to normal managerial reporting relationship convention, we would let people know what we were doing. It is important to say that, on many occasions, we let people know what we had done, because our clear remit was to take action quickly. We made decisions on a day-by-day basis. We had communication with the then Scottish Executive, but most of that was our informing it what we had done. There was no requirement for us to produce a formal report.

The Temporary Convener: I should explain that Alasdair Allan is not a member of the committee but the MSP for the Western Isles. He is welcome.

James Kelly: Malcolm Wright said that the budget was overstated by £4.5 million. The Audit Scotland report states a figure of £1.6 million. Will you clarify that? More important, how was the budget able to be overstated by such a large amount?

Malcolm Wright: The reconciliation between those two figures is explained in an internal audit report that was undertaken. Once we had identified the budget oversetting, some of the pull-back in the budget allocations could be carried out relatively quickly. I would need to refer back to the detailed internal audit report, but I know that there was an underlying £1.7 million that had been allocated out in real terms. I commissioned an independent internal audit report to look at the reasons for that. That report was produced and was then presented to the board's audit committee. We are talking about systems of control and matching income with what goes through the ledger within the board and the finance department. Errors had been made within the board, in terms of basic reconciliation of figures.

James Kelly: It just seems quite astonishing that in working to a £60 million budget, the board can somehow manage to get into a situation in which the sums are out by around £1.6 million. Are you saying that that was related to the ledger systems, in that inaccurate budget information was posted on to the ledgers?

Malcolm Wright: I am not a qualified accountant, but there is a detailed internal audit report on that situation. My understanding was that budgets were allocated on to the ledger, and the reconciliation back to income was not carried out correctly. Once that was spotted, it was relatively straightforward to pull some of that money back, but there was the on-going issue concerning the £1.7 million that we really needed to manage down very hard. There was a very serious breakdown within the board.

The Temporary Convener: Something fundamental within the organisation that should have been working was not working, so what did you do about it? Why was it not spotted before?

Malcolm Wright: I do not know why it was not spotted before, but as soon as we came in we sat down and went through the budgets and the financial recovery plan line by line, and that is what emerged through our work. As soon as it was

spotted, immediate action was taken and, as I said, I commissioned an internal audit report—which is available—to examine the detail of that. To me, the most important thing was to stop the run rate of the money flowing out of the board and to put in place much better control systems that would bring the board back towards financial balance.

The Temporary Convener: We move on to leadership and management.

Claire Baker (Mid Scotland and Fife) (Lab): I have a couple of questions. You have spoken about the terms of reference of the interim support team. Will you say a wee bit more about the objectives that were set by the team, and whether those objectives were achieved? You were here for five months: did you have adequate time and resources to achieve the objectives?

Ronnie Cleland: Are you talking about individual or corporate objectives?

Claire Baker: I am talking about corporate objectives.

Ronnie Cleland: Malcolm Wright has already indicated the eight key items that we agreed with the board. It was important that we had engagement such that the board was signed up to what we were asking it to do. It had to understand why things needed to be done and why it needed to support them, and it needed to know what it had to do in a very short space of time. The corporate objectives were encompassed in the eight headings that Malcolm Wright mentioned—he can expand on that later if the committee wishes. We then translated that into individual objectives for both the NEDs—

The Temporary Convener: We hate acronyms in this committee.

Ronnie Cleland: Sorry—for the non-executive directors as a group and for the executives. As I mentioned earlier, I spoke to each non-executive director to identify what I wanted them to do and what they wanted to do in order to achieve a cohesive unit. We then put in place training and development to help them understand their corporate responsibilities. I can expand on that at some point if members wish.

It was a similar process as far as the individual executive team was concerned. We said, "This is what we want you to do, and this is what we want you to do within six months". We tried at the end of August to make it clear where we were, where we were going and what they had to do to achieve that. We were clear and forceful. We had—as Claire Baker rightly pointed out—a limited timescale, so we had a reinforcing seminar session with everyone in October at which we repeated where we were going and reinforced the point.

10:30

Claire Baker: Did you get to where you aimed to be within that timescale?

Malcolm Wright: We were able to make significant progress, although I cannot report that everything was sorted. George Foulkes asked whether we had enough time or whether we should have stayed longer—I think that that is what he was hinting at. One of the priorities was to appoint a permanent chair and a permanent chief executive, because we were only ever going to be here as part of an interim team. The sooner a permanent chair and a permanent chief executive were in place, the better. The eight areas seemed to me to be—

George Foulkes: You did not succeed in getting a permanent chief executive, though, did you?

Malcolm Wright: A permanent chief executive was appointed and we handed over—

George Foulkes: But he is suspended, is he not?

Malcolm Wright: I understand so.

George Foulkes: Whose fault was that?

Ronnie Cleland: This is a difficult area, convener. It is difficult to discuss the allocation of blame, given the situation with the chief executive.

The Temporary Convener: Okay.

Ronnie Cleland: I am not trying to avoid the question.

George Foulkes: No—it is a difficult situation legally.

Claire Baker: I have one more question. You said that there was nothing that the board could not overcome by itself. Do the current management and board have the appropriate skills and, more important, the appropriate support to address the weaknesses that have been identified?

Ronnie Cleland: At our final board meeting, which I think was on 25 January 2007, Malcolm Wright gave a public presentation on what we had been asked to do, what we had found, what we did about it and where we were at that time. We believed—we have reason to believe that this was acknowledged—that we had made significant progress. There was still work to be done with all the individuals involved at both executive and non-executive levels within the board, and an indication of the requirements was passed on to the new chair and the chief executive.

The Temporary Convener: You stated that you laid down clear lines of progress and what you wanted to be done. Was there a communication problem? Why were those things not done, given that you passed them on for action? You were speaking, but who was listening and acting?

Ronnie Cleland: Do you mean in the handover or during the time we were here?

The Temporary Convener: I mean in terms of the objectives that you put forward for changes that you thought were necessary.

Ronnie Cleland: Many people were not clear about their roles and responsibilities. You asked earlier about resources: we brought in external people to talk about the roles and remits of audit committees, clinical governance committees and staff governance committees, what is expected of them and how they are chaired. Some of the conversations showed me that people were not clear about how those things should be done.

We did not leave it there. We brought people in to try to develop the situation and, as a team, we spent time with individuals to try to ensure that they took on board the training and development, that they understood it and that it enhanced their performance. A lot of work was put in and there was certainly some improvement.

The Temporary Convener: We are talking about fundamental management.

Ronnie Cleland: Yes, we are.

Malcolm Wright: I will address capability and capacity. Western Isles NHS Board is one of the smaller NHS boards in Scotland, and it will always be a challenge to get the breadth and depth of managerial and clinical capacity in a board of its size. We will not get the breadth and depth that is found in, say, NHS Greater Glasgow and Clyde, or NHS Lothian.

We could take the view that, in the Western Isles, we must do everything ourselves and we must have the complete breadth and depth here, but that approach is not likely to succeed. We should take the view that we are part of the wider NHS in Scotland, that we need to link in with clinicians in Highland NHS Board, NHS Greater Glasgow and Clyde, and the NHS in other parts of Scotland as part of managed clinical networks, and that a similar principle applies to management. There are different types of management and we need to link into bigger centres so that their depth of expertise can be drawn on. If the board adopts the mindset that it needs to be part of the wider NHS in Scotland, to draw in available expertise and to link with other boards in order to use that expertise, there is every prospect that it will flourish.

Alasdair Allan: In examining the board's leadership and governance, did you feel that changes needed to be made to the systems and mechanisms for scrutinising senior appointments?

Ronnie Cleland: Are you talking about the structure and the people who held various posts within it?

Alasdair Allan: Yes, and the way in which people were appointed, how appointments were scrutinised and so on. Was that part of your remit?

Ronnie Cleland: No. Our remit was to focus on the existing structure and to find out how to make it work better. Of course, that meant that we had to make some personnel changes in the organisation.

Alasdair Allan: You did not look at the system for scrutinising appointments.

Ronnie Cleland: We did not look at how people had been recruited in the past.

Malcolm Wright: That said, I should add that we also considered the internal audit report relating to the remuneration committee and we considered the committee's effectiveness. The board has to ensure that certain basic governance systems for approving senior appointments are in place.

Ronnie Cleland: That is an important point. We certainly looked at governance issues with regard to the remuneration committee. I thought that the question was about operational issues.

Alasdair Allan: What concerns, if any, did you have about the operation of the remuneration committee?

Ronnie Cleland: We were a bit concerned about the number of times it had met prior to our arrival. I have been in the NHS for a number of years, so I know that the remuneration committee should meet three or four times a year, but it had met nowhere near that many times.

The remuneration committee has a very clear responsibility—we felt that we had make it meet in order to get its membership to understand the remit. I might be slightly wrong, but I think that in the time we were on the board it met three times in six months to deal with a number of issues. I know that it certainly met twice.

The Temporary Convener: Stuart McMillan will ask about finance.

Stuart McMillan (West of Scotland) (SNP): Mr Wright said in his opening remarks that the financial recovery plan that was in place was not adequate, and touched on the various control measures and the system of internal audit reports that were introduced. Will you tell us more about

those measures? Did you propose your own financial recovery plan?

Malcolm Wright: We considered a range of internal controls to deal with certain matters. For example, I have already mentioned the order pads and who was authorised to make expenditure on the board's behalf. We also looked at issues such as central vacancy controls, courses and conferences, and off-island visits.

The board had three medical directors. I felt that a board of its size needs only one medical director who could span primary and secondary care. We also sought to appoint a new head of communications.

I would like to come back to the point about clinical strategy. We certainly tried to address those issues head on and to ensure that the control systems that Audit Scotland would expect were put in place and could be evidenced.

Ronnie Cleland: On the financial recovery plan, we certainly worked very hard on that. Malcolm Wright has just highlighted a number of the actions that were taken.

We were very action-oriented with regard to governance; Malcolm Wright, I and the rest of the team met at least weekly to discuss finances. Malcolm had weekly meetings with the senior management team as and when required. The budgets were examined line by line, and actions were built on that basis. Everybody was left in no doubt that the position had to be rapidly recovered in order that a sustainable position could be created for the future.

Malcolm Wright: We went through the financial recovery plan line by line and tried to put confidence ratings on what was going to be achieved and what could not be achieved. In some instances, there were significant sums of money in the financial recovery plan, but once we got beneath the surface, examined the plans and established who was responsible and whether it was really going to happen in that financial year, a lot of it started to fall away.

We sought to be realistic about what was in the financial recovery plan and what could be delivered, which knocked on to the fact that we needed to deliver on other matters. It was an on-going, line-by-line iterative process. As Ronnie Cleland said, I made sure that the executive team met every week and that the financial recovery plan was on its agenda weekly. I set personal objectives for each director from when we started until when we finished. There was personal performance management as well as organisational performance management.

George Foulkes: Mr Wright said in response to a previous question that there was not, because of the health board's size, the breadth and depth of financial and administrative expertise on the island. I know that it might be a sensitive issue, but did you ever consider suggesting that the health board should join with another health board—not Glasgow—to provide it with that breadth of expertise and knowledge?

Ronnie Cleland: No—we never made that suggestion. What we have alluded to, if we have not said it directly this morning, is that we feel that there is room for mutual support within the NHS family. Some of that support could be fairly close by—Scotland is a small country and it does not take long to get here. We used that support as part of our team. I know that we are talking about finance, but we took some time to involve the human resources director, who came up from Tayside to spend some time with us on staff governance issues and remuneration committee issues. We felt that help and support could be provided to the board in that way. That model would represent a natural evolution in the development of the board without the formality of the restructuring that might otherwise be needed.

Alasdair Allan: When you examined the financial recovery plans, did you consider the underlying financial position of the board? I appreciate that this is slightly after your time, but paragraph 52 of the "Western Isles Health Board—Report on the 2006/07 audit" states:

> "There is evidence that the Board's underlying financial position is in fact more serious than suggested by the overall deficit. Taking into account other income sources and the results of a corporate savings programme, there is evidence to suggest that the Board has an underlying deficit of £8 million, as illustrated … below."

What do you understand by "an underlying deficit", and would you like to comment on it?

Malcolm Wright: What we saw was the accumulated deficit from previous years. The immediate priority for us was to do something rapidly because there was a potential £1.7 million on top of that. It was necessary to put in place control measures, to get the run rate on the cash down and, as a first step, to get the board towards in-year balance. After that, the incoming chair and chief executive would need to take further steps to move the board to greater financial stability. To be honest, we were focused on the fact that we were in a serious situation, which had to be brought under control fairly rapidly.

Stuart McMillan: For clarification, is it correct that no new financial recovery plan was put in place and that you used the existing plan, which was constantly scrutinised and amended?

10:45

Malcolm Wright: That is fair. We went through the financial recovery plan that had been presented to the board line by line. We took that as our starting point and decided that some things in it were not likely to happen, that other things were not likely to happen to the degree that was suggested, that other things were likely to happen and that other things had to be included in it. In that way, we sought to develop the financial recovery plan rather than just starting from scratch.

Stuart McMillan: What dialogue did you have with the Scottish Executive in relation to the financial recovery plan and performance monitoring?

Malcolm Wright: We had regular dialogue with the Scottish Executive, as is consistent for any board in terms of the Scottish Executive's performance management of them. My experience, having been chief executive of two NHS trusts, two territorial health boards and a special health board, is that the boards that are starting to get into difficulty become engaged in much greater and deeper dialogue with the Scottish Executive. We had regular and on-going communication with the Scottish Executive about the situation. It was keen that we should put in place the measures and bring down the deficit.

Stuart McMillan: You say that the communication was "regular and on-going". Was that once a week, twice a week, once a fortnight or as required?

Ronnie Cleland: In a sense, a weekly conversation took place on a number of issues, during which we would say what we had done and what we were doing. I would have that regular conversation, but Malcolm Wright would also be involved in direct communication on financial matters about once a week.

It is important to say that we dealt with things as we went along. Our diaries did not state that there would be a conversation at 3 o'clock on a Thursday. There would be ad hoc conversations, as and when they were required, to ensure that everything was moving in the right direction. The contact was regular.

Malcolm Wright: That is consistent with Ronnie Cleland's appointment by the minister as chair and my appointment as accountable officer with the board. It was absolutely appropriate—in terms of accountability to Parliament—that such discussions went on so that we could keep the Scottish Executive informed about the situation and the actions that we were taking. We were not necessarily requesting that the Scottish Executive do anything, because we felt that the primary responsibility for moving things forward lay with the board. We needed to put in place actions that would rectify the situation.

The Temporary Convener: The board would have to turn the plan for action into actual practice. From where could it get the skills and advice that would allow it to do so?

Ronnie Cleland: We were careful about how we presented issues to the board. We recognised that there were limitations and we took special care in spelling out the issues relating to a particular item, what the action should be and why we were taking that action. In that way, we began to stimulate more informed debate. When necessary, we would set out a broader context for what we were doing.

The Temporary Convener: What help or advice was there for board members who wanted to improve their skills or knowledge in order to assist in those decisions?

Ronnie Cleland: We arranged for people to come in and talk about particular areas and to provide education and development. Occasionally, we sent board members to other health boards so that they could observe what was being done and speak to people about what they were doing. In that sense, there was on-going training and development activity.

Stuart McMillan: From what you have said, there appears to have been adequate support from the Scottish Executive, as well as various discussions and so on. Do you think that there is adequate support from the current Scottish Government to NHS Western Isles?

Ronnie Cleland: I have had no involvement since I departed at the end of January 2007, so I cannot comment on the current situation.

The Temporary Convener: Was that said with a sigh?

Ronnie Cleland: I couldn't possibly comment.

Willie Coffey (Kilmarnock and Loudoun) (SNP): My question is about performance management monitoring, reporting arrangements and so on. The Audit Scotland report states that

"corporate objectives were not agreed"

during your tenure, which was from August 2006 to January 2007. In fact, it took until June 2007—after you had gone—for them to be agreed. However, both of you have said that you set corporate objectives. That differs from the statement in the Audit Scotland report. Can you clarify that point?

Ronnie Cleland: I am happy to clarify that. This morning I have found myself using the words "clear", "clarity" and "clarified" quite a lot. That was the nature of the game. The Audit Scotland report

is correct that the corporate performance management system was fragmented. There was no document that indicated clearly what the board was going to do, but the board minutes show that the areas were covered. I hope that my memory is correct when I say that the paper for the December board meeting included a heading of performance management. It was under such headings that we dealt with matters.

The corporate performance objectives that the Scottish Executive had set were being addressed. As I am sure the committee is aware, those objectives are usually monitored through the annual review. I came up here on 8 August 2006 and we started on 14 August. The minister came to carry out the review on 11 September. We had to put in place a report on what had been achieved and delivered in the previous year. Out of the annual review came a number of clear corporate objectives that we had to deliver by December, so there was a range of work around corporate objectives that had to be done in a short time. I am pleased to say that we delivered that work.

However, Audit Scotland is correct that there was no corporate objectives document. We did not instruct any one to write such a document because we were more concerned about the key areas on which we needed to work and the ministerial imperatives for the end of the year. I invite Malcolm Wright to confirm that that is correct.

Malcolm Wright: Yes. I will add to what Ronnie Cleland has said. The board decided to formulate a board recovery plan, based on the eight areas that I outlined earlier. The plan went to the board in December 2006, which the board decided would form the basis of on-going performance management reporting to the board. Our view was that we needed to move forward on the eight basic areas that had been identified. For example, I regarded partnership working with the comhairle as critical. I was pleased that the community health and care partnership proposals were able to move forward, and by the restoration of full partnership working, the appointment of an employee director to the board and the removal of the vote of no confidence. We also worked hard to resolve the various discipline and grievance cases that I have mentioned.

We have not touched on clinical governance, which we regarded as fundamental. Gordon Jamieson, supported by Jane Adams, led on putting in place a clinical governance strategy for the board. We saw the organisation's clinical strategy as being fundamental. The unsustainability of the model of services that was being operated needed to be addressed. We needed to get the right balance between care that takes place off the island and care that is provided on the islands, and between what happens in the hospital sector and what can be done in the primary care sector.

It seemed to me to be quite a big step to get the scoping paper to the board in December 2006, outlining the main issues for the clinical strategy and the proposed way forward. A new communications manager was appointed, and we carried out some of the things that Ronnie Cleland and I have described to do with corporate governance. The eight points were the framework that we sought to take forward for on-going performance management of the board.

Willie Coffey: Mr Cleland, on your ability as chair to hold your management to account, you have agreed that what the Audit Scotland report says is accurate, and that no agreed corporate objectives were operating internally during the period during which you served the board. Does that explain why Mr Wright said earlier that he did not know why the £1.6 million deficit occurred at an early stage?

Ronnie Cleland: When we came in there were no corporate objectives. We identified eight clear corporate objectives.

Willie Coffey: According to the report, none had been agreed by the time you left.

Ronnie Cleland: I think that there might be an issue of nomenclature. The eight objectives were agreed by the board at its meeting in August 2006 as the key corporate objectives, and that is what we took forward. The outcome of the annual review was that they were objectives that the organisation needed to achieve by the end of December. That is the scope of the corporate objective structure within which we worked.

James Kelly: The basic financial problem here seems to be that the spend was running away from the budget. One way of controlling that is to have a management accounting system in place in which there is monthly measurement of actual spend against the budget to identify variances. Was a system like that in place when you took over in August 2006?

Malcolm Wright: Yes—a system was in place to track expenditure month by month. We needed to take management action and to analyse the information and what it meant, and to decide what action managers needed to take to get expenditure under control. We were working closely with the finance department to ensure that reporting of expenditure was timely so that we could take action.

James Kelly: Was expenditure being measured against the budget at that time?

Malcolm Wright: It was.

James Kelly: When you came in, did you review that system and see any need to put improvements in place?

Malcolm Wright: When we came in, systems were in place in which there were regular monthly reports to the executive team and to the board about the monthly financial position. I guess we felt we needed much more rigorous management action. We needed to ask what the information was telling us: we needed to get below the detail of it and consider the underlying run rate on cash.

James Kelly: So variances between actual spend and the budget were being flagged up but there was no investigation to assess the reason for the variances.

Malcolm Wright: Although I would not like to say that action was not being taken, one of the internal audit reports points to weaknesses in respect of individuals accepting responsibility for doing things about the variances and following through on agreed actions. There were improvements that could be made, such as managers at much more local level getting timely information on which they could base decisions. Improvements could be made and needed to be made.

James Kelly: In summary, there was a basic reporting system in place, but enhancements needed to be made to it to make senior managers and managers aware of the actions that were required to address the financial shortcomings.

Malcolm Wright: Yes. Rigorous management action was needed, for example saying, "We're going to have much stronger vacancy control measures", "We're going to restrict the number of ordering points", and "We're going to look at study leave". That is what we sought to do.

The Temporary Convener: There seems to have been a slip between theory and practice. What system was in place to ensure that what was requested was actually delivered?

Malcolm Wright: All the executive directors of the board had personal objectives that I had agreed. I was responsible for performance management and I conducted performance appraisals before I left. We held weekly meetings of the executive team and we made absolutely sure about the financial position and the financial recovery plan. We went through it tediously, line by line, asking who was responsible for each issue and whether action was being taken. I followed that up with a range of one-to-one or small-group meetings so that we could consider individual projects and really get into the detail and hold people to account for delivery of those projects.

The Temporary Convener: That brings us to the end of our discussion with this first panel of witnesses. Do you have any final comments?

Malcolm Wright: No.

Ronnie Cleland: No.

The Temporary Convener: Thank you for your evidence. If you wish to add anything, please write to us.

We will now have a 15-minute suspension.

11:01

Meeting suspended.

11:17

On resuming—

The Temporary Convener: I reconvene the meeting. We will now take evidence on finance from the second panel. I welcome Mr Ken Matthews and Mr Donald Macleod, who would like to make an opening statement.

Donald Macleod: Thank you very much, convener.

I will tell members about my background. I have 32 years' experience of working in financial environments. I joined the health board in 1990 as a unit accountant and was appointed director of finance in May 1995. I served in that role until November 2004. My last financial report was for the period that ended in October 2004, which is more than three years ago.

Towards the end of my time as director of finance, the finance function implemented a new financial management system known as eFinancials, which is the national system in NHS Scotland. The internal auditors reported that the system had improved the overall control framework and the flexibility and functionality of management cost reporting. Their work on financial controls did not highlight any fundamental control weaknesses. Those two statements are based on what was said in a January 2005 report and a March 2005 draft report. I understand that Audit Scotland's 2003-04 report said that the new financial management system had enabled the board to provide a clearer trail from the ledger to the financial statements.

I was not involved in finance work at all from December 2004 until May 2006, when I left the board, but I was involved with staff who were trying to embed the risk agenda into the NHS board's day-to-day operations. We developed the risk management strategy and tried to develop a corporate risk register and risk management action plans. I also updated standing orders, documentation on decisions reserved for the

board, schemes of delegation and the board's code of conduct. The approach was based on good practice in Tayside NHS Board. A number of those documents are on the NHS Western Isles website. I also set up a system for tracking outstanding audit recommendations. In my final 18 months, the role was slightly different.

In my role as director of finance, the main cost pressures that I experienced towards October 2004 came from locum costs, difficulty in complying with the working time directive—similar difficulties were experienced by other boards—and increased mainland activity. Cases that are dealt with on the mainland are more complex, so treatment on the mainland is more expensive. In October 2004, the costs of GP out-of-hours services, the general medical services contract, the consultant contract, the agenda for change and pay modernisation were starting to have an impact.

In addition, our allocation from the Scottish Executive's funding formula was reducing because our population was dropping. Prior to that year, we had been what is known as a gaining board, in that our uplift was higher than the national average, but with the drop in our population we became what is called a losing board—we received the minimum uplift—which had an impact on our financial position.

Another point that I want to make is that during that period, not only did I leave, but a number of other senior finance staff in the department moved on. Given our combined service, between 70 and 80 years of NHS financial experience were lost. That is all that I would like to say at this point.

The Temporary Convener: My apologies to our witnesses. I now bid a formal welcome to Mr Donald Macleod, who is a former director of finance, NHS Western Isles, and Ken Matthews, who is a regional organiser for Unison. Derek Brownlee has the first question.

Derek Brownlee: In your opening statement, you set out some of the issues that affected the finances of NHS Western Isles. We recognise that some of them are common to all NHS units in Scotland, while some are highly specific to this location. The position now is that there has been a fairly consistent period of deficits. In your view, what underlying problems—it is clear that such problems exist—have led to the deficits of NHS Western Isles?

Donald Macleod: I can comment on 2003-04, which was my last year as finance director. The deficit in 2003-04 was £294,000, which was less than 1 per cent of the allocation. In that year, the deficit came about as a result of a late decision by the interim chief executive to incur some early retirement costs. That is what pushed that year's budget over; we were not planning for a deficit in 2003-04.

In 2004-05, I was involved in the reports that were produced up until October 2004. We in finance reported that if the board did not reduce expenditure and attempt to manage its locum costs, it could be heading for a deficit. We could also see the costs of GP out-of-hours services and the consultant contract on the horizon. At that time, the extent of those costs was generally unknown by boards—they were trying to get a handle on it. The in-year deficit was £444,000 and, as I understand it, there was a cumulative deficit over two years of £738,000.

The deficit for 2005-06, in which I had no involvement, is a significant deficit, which does not seem to correlate with my experience. As I was not involved in that year's finances, it is difficult for me to comment. The cost pressures came from GP out-of-hours services, locum costs, the consultant contract and the agenda for change. There might have been changes to the management structure as well. However, the jump in costs between 2003-04, when the deficit resulted from a non-recurring cost, and 2005-06 and 2006-07 seems quite significant. A deficit started to appear in around 2004-05 because of the cost pressures that I have mentioned. In a small board, such costs are quite significant. It is difficult for me to comment on what happened in 2005-06 and 2006-07.

Derek Brownlee: In general, most of the cost factors that you have mentioned seem to have arisen externally. In other words, they resulted from changes in policy and practice that, as far as I am aware, applied across the NHS and which might have had a disproportionate impact on NHS Western Isles. Are you saying that, although there are underlying cost pressures as a result of the specific geography and recruitment problems, the main change has been as a result of external factors?

Donald Macleod: The main change has been a result of external factors. I would have expected the changes to impact on the board and leave it in a difficult financial situation, but the deficit in 2005-06 seems higher than I would have expected it to be, based on my 10 years' experience. However, I acknowledge that GP out-of-hours provision and so on are cost pressures.

Derek Brownlee: The other side of a deficit, apart from the cost, is the income stream, which you mentioned. You mentioned the change in the allocation. In the time that you were there—you might also be able to comment on what happened thereafter—was the budget allocation received by the Western Isles NHS Board adequate? Is it adequate now?

Donald Macleod: I was the director of finance. Under the old formula, we were a gaining board, which means that we received a higher than average uplift. I would be content with that and would not question the allocation. If I were a director of finance in a losing board and received a minimum allocation, I would tell the Scottish Executive that the allocation was unfair. There is a degree of advantage or disadvantage in the allocation, depending on the circumstances of the individual board. Western Isles NHS Board is in a rural, extremely remote and widely dispersed area from the Butt of Lewis to Barra. Its geography is probably unique; it is made up of a long stretch of islands from north to south, with communities scattered around the spine, which need to be supported by the NHS.

Derek Brownlee: I suppose that you are saying that the funding allocation is okay for a gaining board but not for a losing board. That is another way of saying that the funding allocation is not adequate for boards such as yours, because it does not specifically take into account factors such as additional cost pressures.

Donald Macleod: Yes. Losing boards are given a degree of protection. They will receive a minimum uplift. We were due to lose £699,000 because we went from being a gaining board to a losing board. However, losing boards are protected by the Scottish Executive, which gives them a minimum uplift, which would be 6.5 per cent, whereas gaining boards would get 7.5 per cent or 8.25 per cent. A degree of protection is built in, but the change in allocation would certainly have had an impact.

Derek Brownlee: If I picked you up correctly, you said that, at the time, you were a gaining board, but you are now a losing board.

Donald Macleod: Yes. Under the Arbuthnott formula, we became a gaining board. It was recognised that we needed additional funding, so we were given a higher than average uplift, because of factors such as our elderly population, low birth rate and dispersed communities. Our population then shifted considerably—there was a significant drop in the population. When that was keyed into the formula, our allocation dropped back to the minimum uplift.

Derek Brownlee: At that point, it must have been clear that once such things flow through, they present challenges—to use the euphemism—for the organisation. Was any attempt made to get additional funding or to make the case that the formula was not appropriate to your circumstances?

Donald Macleod: My understanding is that the formula, which was called Arbuthnott 1, was due to be reviewed—there was to be Arbuthnott 2. The primary care element of the formula, which could have impacted significantly, was being looked at. A review was happening, to which we would have fed in.

The Temporary Convener: Every director of finance says that the funding is not adequate. What reassurances can you give us about efficient use of finances?

Donald Macleod: When we were setting the budget, we would always set an efficiency target for budget holders. We would ask them to achieve a 1 or 2 per cent efficiency target and to produce plans for how to achieve it. All through my tenure in the NHS, we set budgets with 1, 2 or 3 per cent efficiency targets. As time went on, it got increasingly difficult to do that. However, we always set a 1 per cent target. The Scottish Executive in giving us the allocation would ask the board to identify its efficiency savings as 1 per cent of its budget.

11:30

The Temporary Convener: Efficiency savings can be a bit of a chimera at times. How much did you succeed in hitting those targets?

Donald Macleod: It was difficult and challenging. I was director of finance from May 1995 till October 2004. During that period, we overspent only once, in 2003-04. That was to do with a one-off, non-recurring cost to which I alluded in my introductory speech. However, I have to acknowledge that, looking into the future, I could see that cost pressures were becoming significant for the NHS board.

Derek Brownlee: When you were in post, what was the mechanism for reporting on the board's financial situation and keeping everyone up to date even in the years when the situation was significantly healthier than it is today? What were the lines of accountability?

Donald Macleod: Even in those days, the financial position was challenging, although we were managing it. We would do a monthly report for each budget manager and a report would go to the senior management team, the executive team and the board. We would also hold what we called team briefs with staff in the hospital community in which we would brief them on finance and usually also tell them what the overall situation was.

In addition to that, each year we had to submit a five-year plan to the Scottish Executive, which would agree the plan. Each month, before the 15th day of the month, we would submit monitoring reports to the Scottish Executive. We would produce a range of reports each month for people down to departmental level and right up to the Scottish Executive.

Derek Brownlee: Are you aware of any change in the reporting mechanism over time or is it essentially the same as it was when you were in post?

Donald Macleod: I would say that it has stayed the same.

Alasdair Allan: What were the arrangements for internal and external audit? Did such a thing exist?

Donald Macleod: My understanding is that the Scottish Executive appoints external auditors. The internal audit was outsourced to an accountancy firm called Deloitte. Rather than each health board in the north of Scotland trying to do its own tender, the boards came together as a consortium to put out a tender for internal services. Private sector firms made bids and Deloitte was successful.

Alasdair Allan: What were the auditors saying towards the end of your time in post at the board? Did they raise any concerns about the way that things were headed?

Donald Macleod: All I can do is quote what I quoted in my introductory remarks. Reports were sent in January 2005 and March 2005. They did not raise any red-flag issues, as they are called. I have the March 2005 draft report here.

Alasdair Allan: Forgive me for not being an accountant, but what is a red-flag issue?

Donald Macleod: There is a red-green-amber system. Green means that things are okay; amber means that there is a risk; and red means that there is a high risk. The auditor did not identify any high-risk areas.

Alasdair Allan: Are you saying that, even by 2004, the auditors did not have access to any material that led them to suggest that any high risks were associated with your finance?

Donald Macleod: Yes, according to the report that I have here. We put in a new financial management system which significantly improved the reporting lines in terms of what are called business objects, which sit on top of the FMS, and gives standardised reports that are used throughout the NHS in Scotland. We were applying good practice. Being a small board, we were not trying to do things on our own. We were keeping our independence but, building on big brother, we introduced the eFinancials system, which was a national system, and we were part of an audit consortium for internal audit. My view at that time was that, with the new FMS, we had improved the financial reporting considerably.

George Foulkes: I will ask something about your introductory statement. You said that, when you left, other finance staff with a total of 70 to 80 years of financial experience left. That is an awful lot in a small board. Why did that happen?

Donald Macleod: I am not sure that I can answer that question. I have 16 years' NHS experience and I think that others who left had 32, 14 and 10 years' experience.

George Foulkes: Mr Matthews seems to want to answer the question. Do you, Mr Matthews?

The Temporary Convener: We should be careful not to stray into territory where we should not be.

Ken Matthews (Unison): Obviously, I am happy to ensure that we do not stray into territory where we should not be. I can comment only as the staff representative for the individuals concerned. I have to declare that discussion of the subject of their leaving is constrained by a confidentiality agreement. Although I requested that that be waived for the purposes of this process, my request was denied, so I can only leave it to the committee to explore that if it so wishes.

Individual senior officers within the finance department were the subject of what we have argued consistently was a fundamentally flawed and hostile finance investigation. Without being too impassioned or unreasonable, I think that there was an element of seeking scapegoats for the financial situation at the time, but I do not want to—

George Foulkes: Who was perceived as being hostile?

The Temporary Convener: I think that we are going down the wrong road here.

George Foulkes: With respect, I do not think that we are going down the wrong road.

The Temporary Convener: I urge caution because all sides would have to be heard. We are entering into the discussion of individual cases so I urge caution; I do not think that that is the way to go.

George Foulkes: With respect, convener, it would appear to be material to the reasons why the health board got into financial difficulties. If a significant number of financial staff—with 70 to 80 years of experience between them—leave, surely the board is going to be incapacitated or find it difficult to maintain financial control.

The Temporary Convener: We need to keep it general, Mr Foulkes.

George Foulkes: It is not mister, but never mind.

The Temporary Convener: Your lordship.

Ken Matthews: Suffice to say that additional information could be made available to the

committee if it wished, but I make it clear that it would be constrained by confidentiality agreements.

The Temporary Convener: We would appreciate it if you could give us that additional information.

George Foulkes: Now that the convener is happier, I will return to easier territory.

There have been other financial recovery plans, Mr Macleod. Why have they not succeeded?

Donald Macleod: Again, I can talk only about 2003-04, which was my final full year. We were planning to break even during that year. We would be in discussion with the Scottish Executive about our five-year plan and year-end position and we would highlight our financial position at meetings with a cohort of directors of finance. In 2003-04, the plan was for the board to break even but, in the end, we went 0.75 per cent over on a one-off, non-recurring basis.

We were managing our finances to a degree at that point in time, while acknowledging that there were costs on the horizon. The situation was slightly different later. Although there was a significant deficit in 2005-06, there was not a significant deficit in the preceding years, although there was an underlying deficit trend—I take that on board, to a degree.

There would be ring-fenced moneys. We were given an allocation for specific things that we were to do, and if that money was not spent, it could be used to help to offset. In my time, that would not have been significant. It was standard practice throughout the board that our internal control statements would have to identify that, although the board had broken even, the ring-fenced moneys of, for example £280,000, had assisted. However, that was true across the board.

In my tenure there was also an opportunity to do a capital-to-revenue transfer or virement. We could vire 1 per cent. We used that facility, but it is now gone. So there have been some changes to the financial regime and the use of capital-to-revenue transfers.

George Foulkes: During your time, what kind of support did you ask for and get from the Scottish Executive to help the board manage its financial position?

Donald Macleod: We were in daily contact with the deputy director of finance of the NHS in Scotland. At that time, we had a financial adviser and support, and we submitted monthly monitoring returns to the Scottish Executive, which would come back and query the figures. There was an on-going monthly debate about the figures and the assumptions.

There was dialogue about the assumptions, which it would test. On occasion, we invited Scottish Executive officials up to the Western Isles because we did not have ready access to them in Edinburgh as others based in Glasgow or at Little France in Lothian would have—they could just pop down to see officials. Officials would come up and we would discuss the financial situation once or twice a year, so there was dialogue back and forth.

Stuart McMillan: I seek clarification. You just mentioned that there were changes to how you could transfer money from the capital to the revenue account. When did those changes take place?

Donald Macleod: It was possibly around 2003-04. My understanding is that it happened when I was still director of finance so it could have been 2002-03, but I cannot say for certain. That facility is not available.

Stuart McMillan: Was it the same situation for the ring-fenced moneys that you mentioned?

Donald Macleod: The same applied to ring-fenced moneys. Boards are given a base allocation and we were given up to 75 allocations throughout the year for various streams. If we could not spend those moneys within the year, they would be ring-fenced and carried forward. I understand that that was still happening then.

Willie Coffey: Will you clarify something that you said earlier about the internal audit report giving a clean bill of health and not putting up any red flags? The figures in our committee papers suggest that at the end of financial year 2003-04, there was an in-year deficit—rather than a cumulative deficit—of £0.5 million. Should we take from that that the internal review did not red-flag that as an issue and that you therefore understood that the board's performance had a clean bill of health that year?

Donald Macleod: With such a deficit we could still have had a clean bill of health to a degree in that we had proper and adequate internal controls in place. The internal review looked at how we processed the payroll and creditors and how we implemented the FMS system—it commented on our internal controls. I am not aware of there having been any comment on the deficit at that point.

The review commented that the board was at risk, but it did not look specifically at the deficit. It looked at how we reported the deficit as a finance function—whether we reported the deficit to the board and whether the board got the right information. For example, the review asked whether my financial report to the board in October 2004 specified what the likely outturn and the key costs were. If we reported that as a

finance function, the review would comment on it and say that the reporting might be inadequate, but that was certainly not highlighted at that point.

Willie Coffey: Was there a perception in the board or from others that, because the report did not highlight the deficit as a red-flag issue, the level of financial performance was somehow acceptable?

Donald Macleod: No, it was not acceptable. However, with the GP out-of-hours contract coming online part way through the year, there was some uncertainty about our figures in 2004-05. In the scheme of things, the figures were up by perhaps 1.25 per cent or maybe not even that much—perhaps 1 per cent of our total allocation in a demand-led service. We identified that the main cost increases might be locum costs and GP provision; how the board would manage that in future—our five-year plan; and how the board was taking that cost pressure out of the equation over a five-year period. That would be the reason.

James Kelly: The recent Audit Scotland report quotes two instances of accruals being incorrectly recorded. In your time, were any audit issues raised about the accrual process?

Donald Macleod: I am not aware of it. One of the accruals mentioned in the Audit Scotland report was a benefit to the board in that we were overstating. As regards prescribing in 2003-04, our information was always two months in arrears and therefore we always accrued two months into our annual accounts. That is my understanding. Obviously Audit Scotland has taken a different view on that or perhaps reporting has changed. At that point, however, we had to accrue two months' prescribing accruals into our figures. I notice in the report that information is now only one month in arrears, which is a benefit to the board.

The Temporary Convener: I want to be fair to all our witnesses, but time is pressing. There is time for two very quick questions.

Alasdair Allan: My question is for Mr Matthews. Should I ask it now?

The Temporary Convener: If you are quick.

Alasdair Allan: I realise that we should not stray into issues about personnel. From a union perspective, did you think that the well-known difficult relationship between the leaders of the board at the time of its greatest troubles, around 2004, and its workforce made it more difficult for the board to cope with its financial situation and to operate efficiently? Did you raise those concerns with the leaders of the health board? Were they available, so that you could raise such concerns with them?

11:45

The Temporary Convener: Please keep your answer on a general level.

Ken Matthews: I will, convener. Through partnership working and the usual reporting mechanisms, staff consistently raised a number of concerns about the breakdown of relationships and difficulties with budgets and service delivery. Mr Foulkes asked about the time that it took for action to be taken. There was serious concern on the staff side that it took so long for there to be intervention.

Claire Baker: My question follows on from the previous one. How do you view current staff involvement in the NHS board? To what extent have staff bought into the recovery process?

Ken Matthews: At the time of the initial interim team, there was an agreement that a partnership finance working group would be pulled together. That would allow formal input to be made from the staff side into the mechanism. There have been difficulties in ensuring that the group meets regularly. I am aware from our representatives and other staff side representatives on the group that it took some time for them even to be given a copy of the recovery plan.

Members report to me that, at service delivery level, they as budget holders have had difficulty obtaining accurate statements of their budgets. I am led to believe that in 2006-07 it took until nearly the third quarter of the budgetary year for budget holders to receive such statements. Clearly, that made it difficult for people to manage budgets effectively at service delivery level.

George Foulkes: Can I confirm that Mr Matthews will provide us with a written submission, containing some confidential information, if necessary?

Ken Matthews: I am happy to support the Audit Committee by providing that information.

George Foulkes: It would be helpful.

The Temporary Convener: I bring this evidence-taking session to a close. I thank our witnesses, Mr Donald Macleod and Mr Ken Matthews.

11:48

Meeting suspended.

11:49

On resuming—

The Temporary Convener: I welcome to the committee Mr John Turner, acting chief executive of NHS Western Isles, and Mr John Angus Mackay, chairman of NHS Western Isles. I invite

John Angus Mackay to make an opening statement.

Mr John Angus Mackay (Western Isles NHS Board): Madainn mhath agus fàilte gu na h-Eileanan an Iar. Good morning and welcome to the Western Isles. I am John Angus Mackay, chair of NHS Western Isles. I confirm that with me is John Turner, acting chief executive of the board. I have been chair since the beginning of February 2007; John joined us in September 2007.

I thank members for inviting us to give evidence to the committee. Although we have been in post and working together for only a short time, we will do all that we can to support the committee in its inquiry. Western Isles NHS Board appreciates the time and trouble that you have taken to come here to conduct your inquiry.

No doubt we will discuss the difficulties and challenges that the board is facing, but I must emphasise to the committee that NHS services are being delivered day in, day out to the people of the Western Isles by dedicated, professional, caring staff who work hard for patients and the public. That confirms what Malcolm Wright said earlier. It is still the case. Key clinical targets are being met and patient service improvements are happening. I believe that the board is fortunate in having such staff working for it.

I am clear that the board has a lot of serious, hard work ahead of it fully to meet the legitimate expectations of us, and we take our responsibilities seriously. We are realistic and determined. Equally, there is an improving picture here, and we can describe to you sound progress and the building blocks that are being put in place. We are continuing and, where possible, accelerating the pace of the improvement that the support team commenced. We are clear about the challenges that we face, and it will take time to meet them to our satisfaction.

In our discussion with the committee, we hope to demonstrate that progress is being made on key areas such as governance, leadership, management, performance management, clinical strategy development and financial recovery. The fact that our latest financial position is forecasting, albeit with tremendous caution, an in-year break-even position is a sign of the necessary progress that is being made on the road to recovery. It is essential that we continue to drive forward that improvement during the next financial year and I am determined that we will do that. Thank you for your interest in the process.

The Temporary Convener: Tapadh leat. James Kelly will lead our questions.

James Kelly: A number of sources have identified weaknesses in the areas of governance arrangements and systems of internal control. The previous two section 22 reports noted significant weaknesses in corporate governance and for a number of years the internal audit reports noted failings in internal controls. In addition, NHS Quality Improvement Scotland noted shortcomings in clinical governance and risk management. Why do such issues continue to arise? What steps have been taken to try to address them?

Mr Mackay: I will make an initial comment before I hand over to John Turner. I continued the process of improving governance that Ronnie Cleland and Malcolm Wright described earlier. However, I took the board back to basics and looked at the Nolan principles, on which governance should be based. I ensured that the board was clear about the distinctive roles that it has at executive and non-executive levels—that it has a stewardship role for the financial, human and material resources that it gets, and that the executive staff are responsible for deploying those resources effectively and efficiently.

We got that clear and we established corporate objectives, albeit that it was May by the time we drafted the first lot and June before they were fully set up. We drafted those objectives because we became aware that we could not drive those principles and practices without having clarity at the top about the corporate objectives. We ensured that the systems were in place. We looked afresh at financial and operational systems to ensure that the objectives could be met.

Mention was made of governance committees. We reviewed the terms of reference of all the governance committees to ensure that they are more in line with the corporate objectives. We continued the process that the support team established. We ensured that the governance committees met regularly. The endowment committee, which had not met for four years, has met regularly during the past year, and I think that the remuneration committee met about five times last year.

In addition, we continued the process of board training and development that was described to you. For example, we held two workshops last year on remuneration issues—one in May and one in September. I could go on, but basically I am trying to say that we reviewed our governance arrangements and we built on the process and the progress that was made by the support team. We have revised all our key documentation, such as our mission statement and the financial recovery plan that you will come to, as well as the scheme of delegation, standing financial instructions, standing orders—the whole lot. In the course of the past year we have put a fair amount of time into ensuring that governance arrangements are tighter than they were at the beginning of last year.

Mr John Turner (Western Isles NHS Board): In the short time that I have been here, since September, I have developed a picture in my head of an organisation that has continued to improve on the actions that were put in place by Mr Wright and Mr Cleland and the team, but which still has a long way to go.

In looking at the internal control environment, I have examined, for example, the internal audit reports, which Mr Wright referred to having commissioned in his time here. In those internal reports, there are 29 priority 1 action points—I think that priority 1 is the same as red flag—and I have reassessed where the organisation is in relation to those points. In my assessment, 18 of the 29 have been actioned, eight are on-going, and on three there has not really been any progress. To my mind, that describes an organisation that is starting to address its internal control environment and is making progress, although there is clearly more to be done.

With regard to the performance management systems that have been put in place, members are probably aware that the Scottish Government sets a number of health improvement, efficiency, access and treatment targets, on which each board has to deliver. There are 28 of those HEAT targets, for example on waiting times access. The executive team now reports regularly through the board on progress in relation to those targets. I am delighted to report, for example, that we met all the December 2007 access targets that we were required to meet.

As members are aware, the organisation's corporate objectives are now in place. I also look at those objectives, and my assessment so far is that good progress is being made on them, although, clearly, as I am sure we will talk about in a few moments, there is much more to be done in the future.

You mentioned the NHS Quality Improvement Scotland report that we received—we have in place an action plan that clearly describes all the requirements upon us in terms of moving forward, and where we are in relation to that. The action plan identifies a number of important things that we still need to take forward, but I have a sense that we are in a much improved environment with regard to reporting and control.

Mr Mackay: One further point on corporate governance is that in the course of last year we have established a corporate risk register, which brings together all the departmental risks. That register goes before the board, so the board is clear about what the situation is in a way that I do not think it was at the beginning of the year.

James Kelly: On a specific point in relation to risk, the Audit Scotland report identified the lack of a disaster recovery plan for the information technology systems, which are obviously crucial to internal controls. An action plan was drawn up and you were tasked with drafting a disaster recovery plan by January 2008. What progress has been made on that?

Mr Turner: Again, I would describe that action point as improving, but there is more to be done. For example, the clinical data back-up systems that were required to be put in place are now in place and operating satisfactorily, but the business system back-up systems are not yet at that point. However, they should be by the end of this financial year. Work has been continuing on the information and communications technology disaster recovery plan, but we do not yet have a draft plan to go to the executive team and the board for approval. Again, I intend that that work will be complete by the end of this financial year.

James Kelly: That would be the end of March.

Mr Turner: Yes.

12:00

James Kelly: As I am sure you are all aware, in 2006-07 there was an overstatement in the budget of £1.6 million. Can you assure us that the budget for 2007-08 has been recorded accurately in the ledger systems? What controls have been put in place to ensure that the overstatement of 2006-07 is not repeated in future years?

Mr Turner: I came into the organisation relatively recently, and I draw a degree of confidence from my relationship with the director of finance and her team and from my relationship with the internal auditor, which is still Deloitte. At the board's audit committee meeting in December, Deloitte was able to report that the budget setting process for 2007-08 had been much improved on the previous process. The auditors said that more remained to be done, but they were clear that the board's process was much improved.

I will reflect on the actions that I have undertaken in relation to the financial plan and performance in 2007-08. The Audit Scotland report refers to the financial recovery plan that was in place earlier in this financial year. In essence, the financial recovery plan said that the board would break even this year and would achieve savings of £800,000, which would be paid back against the deficit that had accrued. As committee members know, Audit Scotland raised serious concerns in relation to that. It is important to state that although the financial recovery plan went through the board's processes, it was not formally signed off by the Scottish Government health department.

When I came into post, I decided that we had to be more realistic about this year's financial position and to develop a new approach to financial recovery. The approach has three strands. It seeks to achieve an in-year break-even position for this year. Because of recent history, I am extremely cautious, but our forecast, based on the position at the end of November, is that we are on track to achieve that in-year break-even position. However, the end of November is only two thirds into the financial year, and we have yet to go through the winter. I have been in NHS management for 20 years so I know that all sorts of things that could knock us off course might be just round the corner.

Once we have achieved an in-year break-even position, our task will be to achieve recurrent balance for the organisation. If we achieve those platforms, we will be in a much more appropriate position to discuss with the health department how we can deal with the deficit that has accrued.

James Kelly: You have outlined the initial plan for a surplus of £800,000. You described that surplus as unrealistic before reassessing it and setting a target of breaking even during this financial year. Scrutiny of the plan will be vital, and it will be a challenge for senior management to drive through the actions required to achieve the targets in the plan. What processes are in place that lead you to be confident that you can break even in the rest of the financial year?

Mr Turner: Just to be clear, I am cautious about the position that we are forecasting.

James Kelly: I appreciate your choice of words.

Mr Turner: The systems that are in place are those that I have had in place elsewhere in my NHS management career and which, I think, you would expect to be in place across the NHS. They involve regular reporting to the executive team, regular analysis and discussion of that reporting on a monthly basis and public reporting to the health board, where there is appropriate scrutiny of the position by the chairman and the non-executives.

Alasdair Allan: It is obvious that the committee has some serious concerns about what happened in the health board in the past. It is worth putting on record the fact that the community here appreciates the work that the NHS does in the islands. I believe that there is the beginning of some optimism, which is down to some hard work that is being done.

I appreciate that Audit Scotland's report dates from July and that you have been in office since September, but, on page 20 of the report, there is a reference to a lack of strategic priorities. Can you elaborate on what you have been doing to turn the situation round?

Mr Turner: In my view, NHS Western Isles has a significant problem in terms of looking to the future as it has no clear plan for the future. Malcolm Wright described to you some work that he put in place to develop a clinical strategy that would describe how services are to be delivered to the people of the Western Isles over the next five to 10 years. Only when that overall strategy is in place will we have the framework against which appropriate financial plans, workforce plans, IT plans, estates plans and so on can be made.

With regard to the picture that I have in my mind of an improving situation with more to be done, the work that Malcolm Wright commissioned in his time led to a document being produced in the summer of last year by the health board on the future direction of clinical services, which resulted in a good framework. The responsibility that I, the board and the executive team now have is to transform that framework document into a more detailed clinical strategy for the future that describes the health needs of the people whom we serve and how we will meet them over time.

We need to deal with the crucial issues of the balance between hospital care and community and primary care, joint working between the health service and social care services and the balance of secondary care provision between the Western Isles hospital in Stornoway and the mainland providers—primarily, but not exclusively, Raigmore hospital and the hospitals in Glasgow. All that needs to be taken to a stage of clarity so that the board has a clear strategic plan for the future that is affordable and ensures that all our plans, including our financial plans, can be geared in relation to that overall strategy.

Alasdair Allan: You have set yourself some ambitious long-term targets in relation to the historic deficits. Does either of you want to talk about that side of things? Does that form part of your plan for the future?

Mr Mackay: As John Turner said, the initial priority is to ensure that we maintain control over the budgets. We need to maintain a balanced budget during this financial year and to move towards maintaining a further balanced budget in the next financial year, based on recurrent savings more than on non-recurrent savings. In developing the clinical strategy, we need to map out the way ahead for subsequent years and, as John Turner said, to engage in a dialogue about how best to deal with the deficit in the coming period.

Realistically, against the background that has been described for you this morning, we have a tough task over the next couple of years to get our budgets in line. We have a workforce plan and we have the building blocks, but we must bring them together. One of the positive aspects of the current situation is that we are moving into a new phase of

Government policy, with the "Better Health, Better Care: Action Plan" and the development of e-health. There is a lot of scope for us to look afresh at the situation so that we can realign the finances, the workforce and all the material aspects of our budgets with the requirements of the Western Isles—not the requirements of the past, but the requirements of the future.

Mr Turner: Approximately 50 per cent of our money goes on staff, and a further 20 per cent, roughly, goes on drug costs, prescribing and the costs of mainland providers. Clearly, there are some drivers for our cost base. Since the turn of the millennium, there has been a significant increase in the staffing establishment of NHS Western Isles. My understanding is that the number of staff employed in 2001-02 was 660; in 2006-07, it was 840. The NHS has been growing through a period of development, but I have a sense of the appropriate rigour in managing the staff establishment at a corporate level. I am considering that for the future, with a clear workforce plan that supports the developing clinical strategy.

George Foulkes: That seems to be the most significant point that we have heard today. Mr Turner described clearly what the clinical strategy should incorporate. There are the workforce and the IT estate to consider, as well as the balance between health and social care, between the primary and secondary sectors and between the Western Isles and the mainland. You have diagnosed the problem, but when are we getting the remedy? When will you be able to say, "This is the clinical plan"? Will you still be here?

Mr Turner: We should bear in mind that the clinical strategy will be for the people of the Western Isles. I regard it as essential to have full engagement and involvement in the next stages of the development of the strategy, not only with the people whom we serve but with the voluntary sector and council services, as well as our own staff up and down the islands, including hospital and community staff. That is a significant undertaking. We take that seriously, and we will take part in a full process of engagement, involvement and development.

We are aware that anything that we develop is likely to be subject to the independent scrutiny approach that the Government is putting in place, and to appropriate public consultation. I am concentrating on getting the process of involvement and engagement right. That will take time. I hope that, by the end of this financial year, we will have made decent progress and will be able to describe how the work is moving forward. Being realistic, I suspect that it will be well into the new financial year by the time we have a firm set of proposals and options.

12:15

George Foulkes: Will your appointment as acting chief executive last for a period of time that will encompass getting those things into place?

Mr Mackay: That is a difficult question in the circumstances in which we find ourselves. John Turner said that he can permit himself to deliver certain things until the end of the financial year, and I can confirm that what he said about the management objectives that have been set for him until the end of the financial year was right. However, I cannot comment on the position that we are in with regard to the current chief executive.

George Foulkes: But that is a crucial issue. There have, in effect, been three acting chief executives: Malcolm Wright, Laurence Irvine, who was suspended, and John Turner. If you want consistency and success, you will need a chief executive for a longer period of time to see things through. Why is that a problem?

Mr Mackay: You have put your finger on a day-to-day problem that I have to face, and I share your concern. However, the current chief executive has been suspended without prejudice and an investigation is being carried out. We expect that John Turner will stay with us while that investigation continues, which it will do so for some time. I cannot predict the outcome of the investigation and I cannot confirm that John Turner will be the chief executive after that period, as due processes will need to be gone through. However, it is a worry.

George Foulkes: Right. So John Turner will be acting chief executive as long as the suspension continues.

Mr Mackay: Yes.

The Temporary Convener: We will now consider leadership and management.

Stuart McMillan: Do you agree that there have been difficulties with recruiting and retaining managers?

Mr Turner: It is clear that there have been difficulties in the past, but I would like to build on points that Malcolm Wright made about ensuring that we have sustainable arrangements in place that will deliver high-quality, professional leadership and management for the board. Malcolm Wright reflected on the need for NHS Western Isles to be part of a management network and a clinical network with the rest of the NHS in Scotland, and I strongly share his view.

In my first few months in my post, I have, with the support of the Scottish Government health department, drawn on my personal network across Scotland and drawn in expertise and support from

the mainland to help us. For example, I have enlisted support from the director of finance of a mainland health board and from our internal auditors to consider systems of financial planning, control and discipline in the organisation. I have enlisted the support of a senior medical director from NHS Greater Glasgow and Clyde to work with me and our acting medical director to consider significant issues that we must face in supporting the medical community to move forward in the islands together, in line with our emerging clinical strategy. I have also enlisted the support of a senior employee director from the mainland to work with me, our employee director and the rest of the team to consider how to progress staff governance issues. In addition, I have commissioned work from the mainland on how we look at the estate for which we are responsible, from the top to the bottom of the islands.

We are not drawing in people to tell us how to do things. People with many years of experience and wisdom are working in partnership with us. They are supporting us and helping us to move forward. That partnering arrangement between managers in the service in the Western Isles and colleagues from the mainland will strengthen our moving forward together.

I should stress that I have considered with the council's chief executive how the health board and the council can work far more closely together in the future. I believe that there are opportunities for us to work together as joint leaders and managers of the services, to share the ways in which we work, to support each other and, through that, to maximise the impact that our services have for the benefit of the people whom we serve.

Mr Mackay: I will cut to the chase in relation to your question. It is obvious to me that, in NHS Scotland, no board is an island: we are part of a system. What John Turner described is absolutely in keeping with what the board understands its position to be. When there are capacity issues we look for support, rather than brush them under the carpet.

To me, there are two prerequisites for the future survival of the board. One is that we get our house in order internally, with whatever support we need from NHS Scotland in a range of disciplines. Sometimes it will be one discipline and sometimes it will be another, but we will follow that through as a natural process. The other prerequisite is that we have good, strong links with our local partners in the public and voluntary sectors. We are working on both of those prerequisites.

Stuart McMillan: Does that mean that the people whose support you have enlisted are not full-time employees of NHS Western Isles?

Mr Turner: Absolutely. They have substantive jobs elsewhere in NHS Scotland but they agreed to work with us on an individual basis for a number of days a week. They will work with us on an open-ended basis for as long as it takes us to get to where we need to be. I am exceptionally grateful for their support.

Stuart McMillan: Is it possible that when the term of your acting position ends, the term of the people whose support you have enlisted will end as well?

Mr Turner: I return to two previous points. First, I had the support of the Scottish Government health department in enabling the links. I discussed the approach with the Government and I have its support. It shares our view on the approach and the importance of our linking with others in the way that I described. Secondly, as John Angus Mackay said a moment ago, it is essential to develop such relationships if we are to have a properly functioning, well-led, well-managed health board for the people of the Western Isles.

The Temporary Convener: We are dealing with substantial and substantive matters, but I must ask colleagues to ask sharper questions, because we have a fair bit of material to get through. Mr McMillan, have you completed your questions?

Stuart McMillan: I have a couple of questions on other aspects.

The Temporary Convener: Will you make them short and sharp?

Stuart McMillan: Okay.

Paragraphs 4 to 7 of the section 22 report, which was published in October 2007, highlight the possibility that the board's management and leadership skills are not what they should be. How confident are you that the management and the board have the leadership skills and the financial expertise to bring the board back to financial stability? I highlight your earlier comment about the break-even point and the need for extreme caution about the position.

Mr Turner: You will understand that, as I came into the board relatively recently, I am still open-minded and thoughtful about the current management arrangements and what they should be in the future. Throughout the management team, but also throughout the services, I have detected a real willingness from people to put their shoulder to the wheel to make the improvements that we need to make as a system. There is a huge commitment from front-line and management staff to help us to take the organisation forward and make further improvements. As we discussed, the mechanism that I described of partnering up and securing mentorship and support from people

on the mainland, where appropriate, will be an essential ingredient in moving forward.

Mr Mackay: I can make an additional point linking the board's and executive's roles. The board's capacity in financial terms is in question—we had a financial recovery plan, and you might ask whether we interrogated it well enough. In the current situation, board members are very aware that as lay persons they often need a lot of support in dealing with complex financial matters.

Although internal audit has confirmed that the budget-setting process for this year is much more robust than in the past, we will run a training seminar for board members in two weeks with Deloitte to ensure that we know the questions that we should ask and the answers that we should look for, and when in the year we should do that. That will ensure that we concentrate on being not just efficient but effective. We have to do the right things as well as do them right.

To illustrate the improvement that John Turner has described, we recognised during the past few months, particularly in considering how clinical strategy might develop, that we had to rationalise our operational structure. We therefore created one operating division—that was John Turner's recommendation—and the post of chief operating officer. I am pleased to say that we have recruited a high-calibre candidate to that post, and they will start early in February.

Stuart McMillan: I have one final brief question. Do you agree or disagree that the frequent changes in management have negatively affected the performance of NHS Western Isles?

Mr Mackay: I disagree, and I am very pleased to be able to say that.

We continued to hold the line through the year, as described by Malcolm Wright and Ronnie Cleland, and we got to grips with governance issues. By the middle of the year, we had a different system of financial reporting—a system that allowed the board to be clearer about the issues. I well remember that at a board meeting in June, after a finance workshop, the key issues that were still holding us back jumped out from the page that the director of finance gave us. They were the issues that John Turner referred to: locum costs, prescribing costs, service level agreements with mainland areas and so on. It was clear by that time what position we were in.

The process of questioning the chief executive started from 3 July, although he was in position until September—you can well imagine that that was a difficult period. However, we held the line as a board as much as possible with the executive team as it was then. As I hope we have demonstrated today, John Turner took over, hit the ground running and the rate of progress has accelerated, rather than fallen back. I know that there was a risk, and I am pleased that it was identified as a risk, not only so that I could answer your question, but because, after it was identified as a risk, we worked hard to ensure that it did not materialise.

The Temporary Convener: We are seriously behind schedule, so we will move on.

12:30

Claire Baker: I will pick up on a couple of issues that have been highlighted by Audit Scotland. You have given us assurances about the level of health care that is delivered in the Western Isles. Do you think that the poor financial position that NHS Western Isles has found itself in has had any impact, particularly on partnership working and the development of the community health partnership?

Mr Mackay: The community health and social care partnership was established in June last year. Part of the health board contribution was put into the CHASCP right away and a joint services committee was established. The local authority's contribution will come on stream at the beginning of the next financial year. Given the relationship that we have established with the local authority at the highest level—the convener, the two chief executives and I meet regularly—we are able honestly to discuss our financial situation. We came into that limping, in a sense, because of our financial situation. The local authority recognised that and it did not damage our relationship. People are positive about moving forward in that environment.

Mr Turner: I will reflect on my experience. The chief executive and convener of the council have gone out of their way to develop a positive, workmanlike, forward-looking relationship with John Angus Mackay and me, which has manifested itself in monthly meetings between the four of us. I have regular contact with the chief executive of the council. At the beginning of December, we had a meeting in the council chamber with all the councillors to discuss our hopes for the health board and the relationship between the health board and the council for the benefit of the people whom we serve.

Willie Coffey: I must ask you to clarify some aspects of the financial reporting that you have told us about today. The section 22 report suggests that an £800,000 surplus was forecast for the current year. You said a wee while ago that you expect the figure to turn on balance at zero. Audit Scotland reported previously that a more realistic outturn figure for the current year would be a deficit of £300,000. That tells me that we are lurching from one estimate to another.

What assurance can you give us and the public whom you serve that what you are telling us, and therefore the public in the Western Isles, is more reliable than what has been said before? You sent a letter to Hugh Henry about the £300,000 savings in relation to services delivered on the mainland. Are we talking about services that have been cancelled and will not be delivered to the people of the Western Isles, or was there simply an overestimation of the cost of such services?

Mr Turner: My understanding of where we are, and the recent history, is that early in 2007-08 the board set itself a target of breaking even in-year and producing savings of £800,000 on top of that, which would be paid back as part of the deficit. That was never agreed with the health department—it was not signed off. The position that I have agreed is that we should concentrate all our efforts on seeking to break even. That is what I have reported to you.

On the reliability of what I am saying to you, you will sense that I am cautious about being categorical. That is simply because trust, confidence and understanding between the chief executive and the executive team and so on take time to embed. All the measures that Malcolm Wright and his team put in place have been maintained by my colleagues. Many of the measures will take time to bite and take effect in terms of financial improvements, but you will see from this year's reports that the measures have delivered a fairly consistent anticipated in-year overspend this year of £300,000 to £400,000.

I have undertaken a line-by-line review of our financial recovery plan and identified a number of key areas that we need to tackle, some of which will take time. However, one of the earliest issues that I addressed was the cost of services provided by the mainland providers. I found that the estimated costs in the budget had not been rigorously assessed and reviewed with those mainland boards. I have since undertaken that process, and to date it has delivered some significant savings. I am still casting my eye over the matter, in terms of the rest of this financial year and the arrangements going forward. However, to answer your question, there has been no diminution in the number of patients who are able to access the services: there has simply been, in a sense, a renegotiation of the cost.

Alasdair Allan: In putting together a financial recovery plan, I know that you want to ensure that services remain sustainable. The following specific point was raised:

"the Board is unable to comply with working time directives without incurring unacceptable levels of Locum/Agency Costs."

Will you elaborate on that?

Mr Turner: Yes, I am happy to. The cost of medical locums is one area—along with service level agreements and prescribing—in which there is significant and increasing expenditure. I mentioned earlier that I have enlisted support from a senior medical director from the mainland, who will work with me and the acting medical director. Part of his role will be to assess the patterns of expenditure on medical locums. We will always require medical locums, but he will develop what I hope will be a more effective approach to enlisting their services, involving a high degree of control and discipline.

Willie Coffey: Have the savings that you mentioned been agreed with the service suppliers on the mainland? Do you think that you will save the £300,000?

Mr Turner: Yes.

Willie Coffey: And will people still receive the services?

Mr Turner: Absolutely.

George Foulkes: How have your financial problems impacted on service delivery?

Mr Turner: In his opening comments, John Angus Mackay talked about the quality of care that is delivered to the people of the Western Isles by our staff day in, day out. As I said earlier, we are in line to meet all of our key waiting and access targets. December 2007 was a key point for a number of those targets. The targets for cancer and for out-patient and in-patient access times were all delivered.

I have spent a lot of time in open meetings with staff, and I sense that staff throughout the Western Isles want to work with us not only to continue to deliver quality services, but to ensure that they work for a healthy organisation that is in financial balance and is looking positively to the future. I am hopeful that that staff support will enable us to move forward confidently in delivering patient care day in, day out.

George Foulkes: Do you think that you will be able to meet your targets and continue to provide an adequate service even in your current financial position?

Mr Turner: We are clear that that is our responsibility, but we will do it only by working in partnership with our staff, the council and, as I have said, the mainland boards.

George Foulkes: And you predict that you will break even at the end of the current financial year.

Mr Turner: I am saying that our forecast after month 8—the end of November—is that we will break even at the end of this financial year, in-year. I have said enough about how cautious I am in making that statement.

George Foulkes: And the $64,000 question: you could be required to pay off the accumulated deficit or, alternatively, we could recommend that the accumulated deficit be written off. Which option would provide the better incentive for the board?

Mr Turner: In my view, our responsibility is to take this one step at a time. That will grow confidence in our financial management and in our relationship with the Scottish Government health department. What one step at a time looks like to me is to break even in-year and move to recurrent balance. That will put us in a position of confidence in the discussions about how we deal with the deficit that has accrued.

George Foulkes: If you were required to pay off the deficit, would that put undue strain on the board? John Angus Mackay is nodding.

Mr Mackay: Being realistic, obviously it would be very difficult to repay £3.4 million in one or even two or three dollops, given the situation that we are in now and given that we are in a tighter financial environment than we have been in for the past five or six years. I am sorry to come back to a point that John Turner has also made, but only when we have a clear picture of what the clinical strategy looks like and what the service requirements are in a changing environment in a modern health service can we be clear about the answer to the question. In the meantime, it is tough enough to balance the books. I hope that you will do anything that you can to help us over the next few years.

Stuart McMillan: What proportion of the proposed savings for 2007-08 is recurring? How will you replace any non-recurring savings in the following years?

Mr Turner: If, as I am cautiously suggesting, we break even in this financial year, that will be achieved using just over £2 million of resource that is currently classified as non-recurring. As an executive team and a board, we have the opportunity to turn not all but a good proportion of those non-recurring savings into recurring savings in the future. Sorry if I am being slightly opaque, but it is about the classification of those savings as non-recurring. As I say, we have opportunities to turn them into recurring savings in the future. An example of that would be staffing numbers, which I mentioned before. A number of posts in the organisation have been vacant for more than 12 months. We need to take a view about whether it is sensible to hold those posts or remove them from our staffing establishment.

The Temporary Convener: James Kelly will ask the final set of questions, on performance management arrangements.

James Kelly: I have a couple of questions. You have said a lot about how you are striving to break even this year. I appreciate that you are reluctant to talk about the financial projections in the longer term, but do you have a long-term strategy for the health board?

12:45

Mr Turner: As I said earlier, we are developing a clinical strategy for the future, and it is absolutely essential that that strategy is underpinned by a financial plan that, instead of focusing on how to get through the next financial year, takes a long-term, three to five-year view of our income and expenditure, service changes, developments, investments, disinvestments and so on. I also referred earlier to the support that we are receiving from the mainland director of finance in the internal audit to help us with financial discipline and planning.

Mr Mackay: You have already heard a lot today about the board's underlying financial position, and we have to drill down pretty deep to identify what the underlying pressures have been and are in order to deal with them and to build for the future. That is not something that we can do either in a day or in a week, but we are clear that we have to do it and indeed are determined to do so.

James Kelly: I appreciate that these issues are complex and have no quick-fix solutions. You mentioned that you wanted a long-term, three to five-year plan that would cover clinical and general strategies and would link into the financial figures. Do you have a timescale for developing that plan?

Mr Turner: Again, I draw on my earlier comments about the importance of getting the process of involvement and engagement right. I expect that it will be the new financial year before we have a properly worked-up set of proposals and options—which, of course, will then be subject to appropriate scrutiny and consultation. As I have also said, I hope that by the end of this financial year I will be able to demonstrate significant progress on this matter. I realise that I am repeating myself, but it will be the new financial year before we have those proposals and options.

James Kelly: So you hope to produce in financial year 2008-09 a long-term strategy that links to the numbers in play.

Mr Turner: That is correct.

James Kelly: I know that some of this issue has already been covered, but will you describe the process by which the board receives information to review? How do you then review that information with management and assign actions?

Mr Mackay: Board agendas are structured on the basis of accountability and allow us to look, for

example, at performance on HEAT targets. As Ronnie Cleland said earlier, every board meeting has an item on performance management to ensure that we receive information on performance on national targets and targets in the local development plan, and we also regularly have an item in which we look at how we are doing on finance. Moreover, at every board meeting, we receive approved minutes of the meetings of the board governance committees, attached to which are action lists that detail the key points of action with regard to clinical issues, staff issues, financial governance issues, the patient focus and public involvement framework and so on.

In that way, the board takes into account the views of the executive, which meets every week and can discuss all this information in more detail than any board might be able to at one meeting. There is a flow of information from the executive team to the board, which is now better placed to question matters. There is also an on-going programme of training to ensure that we are asking the right questions and looking for the right answers.

James Kelly: We have been given a sample delivery plan with key performance indicators. It is colour coded—red means that you are not performing to plan. Can you confirm that, where there is a red flag, to use the phrase that was used earlier, an action plan with a set timetable will be put in place for a particular manager or group?

Mr Turner: Yes.

Mr Mackay: That comes back to our performance management arrangements. Once relevant performance objectives have been set, the chief executive will review them in the course of the year. At the end of the year, the remuneration committee, which will have followed the process throughout the year, will be in a position to know whether the executives have delivered.

George Foulkes: I am having to get used to different definitions of a red flag.

In earlier evidence, we were told that budget holders are not given their allocations until the third quarter of the year. Why is that? What are you doing to sort out the situation?

Mr Turner: My understanding is that that was the case in a previous financial year. I refer to my earlier comment that our internal auditor, Deloitte, has reported to the board's audit committee that the budget-setting process for 2007-08 was much improved.

Mr Mackay: We can confirm that, in December, our audit committee specifically asked whether the budget-setting process for this year would be done well in advance of the end of the financial year. The answer to that is yes.

George Foulkes: Right.

The Temporary Convener: Claire Baker will ask the final question.

Claire Baker: It follows on from George Foulkes's question about staff involvement. Could we hear the views of the chief executive and the board on whether staff feel committed to the process and recognise that it is down to staff at all levels to achieve the necessary savings? Have those relationships improved?

Mr Turner: I can speak about my relationships with staff only from my experience since I came here and can go on only what they have said to me, which obviously might not reflect how they feel.

As I said, I have spent a lot of time having open staff meetings, talking to staff about the challenges that we face and listening to their views, opinions and experiences. We already had a much-improved internal communications programme, the development of which was kicked off by Malcolm Wright's team. We now have a communications manager in place. There is an internal message system for staff called finger on the pulse and we have a staff intranet, on which staff are asked questions and can post comments on a variety of subjects.

In all my meetings with staff, I have been struck by how much they want to be part of an organisation that is working well. It is clear that they are exceptionally committed to patient care, but there is something about wanting to belong to an organisation that is healthy, positive and viable in every sense. I have left all those meetings feeling quite humbled by what staff have said to me about their experience in recent times and their support for us to make progress as one team. There is no one else here on the Western Isles, so it is down to us. It is clear to me that we have a responsibility to work with our island partners as one team in the interests of the people whom we serve.

The Temporary Convener: We have covered a great deal of ground during this morning's session, which will be extremely helpful to the committee in our deliberations. I thank Mr Turner and Mr John Angus Mackay. Your evidence has been about achieving future improvement and everyone wishes you success in that work.

We now suspend our meeting, which we will resume at 1.30 this afternoon for further evidence taking.

12:54

Meeting suspended.

13:36

On resuming—

The Temporary Convener: I open the afternoon session of the meeting and welcome to the committee Dr Kevin Woods, chief executive of NHS Scotland and director general of the Scottish Government health directorates. He is accompanied by his colleagues Paul Martin, director of the health workforce directorate; Alex Smith, director of the health finance directorate, and Alistair Brown, deputy director of the health delivery directorate. All are welcome.

I invite Dr Woods to make an opening statement.

Kevin Woods (Scottish Government Health and NHS Scotland): Thank you convener, and thank you for inviting me and my colleagues to give evidence to the committee. I thought that it would be helpful to offer the committee some context on NHS Western Isles.

The board's financial deficit, which we are considering, arises against the background of a significantly higher per capita budget than any other health board in Scotland, or indeed in the United Kingdom, having increased at a rate higher than inflation for the past decade. During the past three years, the board's core funding has increased by an average of 6.7 per cent, ranging in those three years between increases of 6 and 7.3 per cent.

The number of people working for the board has also increased significantly. The number of whole-time equivalent employees of NHS Western Isles has risen from 660 in 2001 to 843 in 2006-07. That gives some indication of the growth in the organisation and the services that it provides.

The revenue resource limit is a key target for NHS boards to contain their expenditure. It provides them with the resources to run their services. We in the Scottish Government health directorates monitor the boards' performance against that target throughout the year to seek assurance of their financial positions.

In the case of NHS Western Isles, it is possible to identify financial pressures as far back as 2001-02, but in that year they were offset by technical accounting adjustments. In the following year, 2002-03, the board's position deteriorated but, using the flexibilities that were available to the board at that time—such as capital-to-revenue transfers, slippage to ring-fenced allocations, and brokerage—a small surplus was reported, which was noted in Audit Scotland's report for 2003.

Of course, by the year end of 2006-07, the board reported an in-year deficit of £880,000 and an accumulated deficit of £3.364 million.

It might be helpful if I try to outline for the committee how we assess a board's financial position. We do not look just at their in-year performance; we also look very closely at their underlying recurring position because we want to ensure that boards do not place too much reliance on non-recurring income, or the flexibilities to which I referred a moment ago, to underpin their recurring commitments. Indeed, boards can no longer rely on capital-to-revenue transfers, brokerage or the sale of assets to achieve end-year financial balance. The department continues to challenge all boards about any overreliance on non-recurring incomes to sustain their recurring position. The Auditor General's overview report on NHS Scotland, which he published in December last year, demonstrates that we have made quite considerable progress on that challenge across the health service in Scotland.

That is the same approach that we have adopted in relation to NHS Western Isles, and in so doing, we have sought to ensure that the board followed due process in dealing with financial, clinical and staff governance issues. We have required the board to submit viable financial recovery plans, and we have also tried to make available significant support—particularly HR support—to the board.

However, despite those efforts, the board did not deliver financial balance and, by the middle of 2006, ministers reached the view that the board was not making sufficient progress. The resignation of the chairman in the summer of 2006 led the then health minister to appoint Ronnie Cleland as a seconded chair on an exceptional basis and to the appointment of the support team. Shortly thereafter, the chief executive of the board at that time was seconded out to another position with NHS Scotland and Malcolm Wright became chief executive.

I visited Stornoway with the then Minister for Health and Community Care, Andy Kerr, in August 2006 and he strongly emphasised the importance of all the people in the board working together to address the failings in governance arrangements—which were evident—and to ensure tight financial control, as well as to improve internal relationships and relationships with external partners, particularly the council. As planned, the support team withdrew in January 2007, John Angus Mackay was appointed as substantive chair and a substantive chief executive was appointed. Unfortunately, that chief executive is currently suspended while an investigation is under way. The board sought assistance to identify an acting chief executive and John Turner has filled that role since October 2007.

The board's in-year deficit peaked in 2005-06, it improved in 2006-07 and the board is now—as you might have heard this morning—cautiously forecasting to break even in-year in 2007-08. I should perhaps make it clear, however, that we are clear that further work is required to ensure that that is sustainable on a year-on-year basis. We also need to consider the board's accumulated deficit once budget balance has been demonstrated. This has undoubtedly been a very difficult period for the board. Throughout it we have sought to ensure that the board discharged its duties to address its difficulties and to follow due process in all its actions, all the while giving support as best we could from central Government.

I hope that that summary is useful to the committee in setting out the context. My colleagues and I will do our best to answer any further questions.

The Temporary Convener: That is appreciated. George Foulkes will now look at governance arrangements and systems of internal control.

George Foulkes: That was a helpful introduction. This is the third consecutive section 22 report from the Auditor General—what action did you take following the first two?

Kevin Woods: As I explained, we are very proactive in our relationship with boards over these things. We have a protocol, which I have outlined to previous Audit Committees, on how we monitor boards' performance. We generally ask for a recovery plan, which we test to see whether it is viable. On occasion, we have not been satisfied with the recovery plans from a board. We are constantly in dialogue with the boards to take a look at their plans and to seek assurance that they are addressing the points that have been raised in, for instance, the reports of Audit Scotland.

George Foulkes: But it is clear that the board was not addressing the points. The deficit was accumulating and although you were seeing it accumulate you were not taking any decisive action, were you?

Kevin Woods: We were being given assurances that the board was indeed addressing the underlying financial issues.

George Foulkes: Successive financial recovery plans clearly did not result in financial recovery.

Kevin Woods: Indeed, and that was one of the reasons that eventually led us to take some of the action that we took.

George Foulkes: But the chief executive at the time that all this was happening was put there by you or your predecessor. Is that not right?

13:45

Kevin Woods: No, the chief executive at that time was appointed by the board. He had been an interim chief executive prior to that. The department's assistance was sought by the then chairman during a period when I think that the then substantive chief executive was on sick leave.

George Foulkes: So Dick Manson was not put in initially by NHS Scotland.

Kevin Woods: He was identified by my predecessor as someone who might be able to assist the board. The board had requested that assistance. As I understand it, the then chairman was happy to have Dick Manson's services. Subsequently, when the substantive job became available he applied for it and was appointed.

George Foulkes: What kind of dialogue did you have with David Currie and Dick Manson about the growing deficit during that period?

Kevin Woods: We had numerous discussions. It might be helpful if I invite my colleague Mr Smith to say a little about the processes that the finance team use to stay in touch with the detail of boards' positions.

Alex Smith (Scottish Government Health Finance Directorate): We have regular dialogue with the accountable officer, who is the chief executive, and with the finance director, who is key to corporate governance and financial sustainability, viability and so on within the boards.

I have been in contact with the finance director on a monthly basis during the two years that I have been in post. We follow regularly the protocol—mentioned by the chief executive—that is available to the Audit Committee. The health finance directorate receives submissions from all NHS boards every month. We scrutinise them according to the protocol, we engage in dialogue with boards if any issues concern us and we take appropriate action.

George Foulkes: In his introductory remarks, Dr Woods said that Western Isles NHS Board received a higher per-capita allocation than anywhere else in Scotland or the UK and that it has been increasing. However, the Western Isles is unique in the United Kingdom because of its several islands and sparse population, so the allocation is understandable. Is it conceivable that we have not been giving it enough money to take account of all that and that that is why the board got into difficulties?

Kevin Woods: I am not sure that the Western Isles is unique. We have communities in Shetland and Orkney that similarly face significant pressures. However, I acknowledge that there are particular issues in the delivery and funding of

health services in remote and rural areas—there is no question about that. That is why, under the resource allocation formula that we currently use to determine allocations to boards, we have a specific adjustment for the excess costs of care delivered in remote and rural areas. Notwithstanding that, the Western Isles is receiving about 50 per cent more per capita than the Scottish average—Mr Smith will correct me if I am wrong—and significantly more per capita than Orkney or Shetland.

George Foulkes: I will leave it to Dr Allan to argue the case that the Western Isles is even more in need than Orkney or Shetland. Geographically, Orkney and Shetland are both more compact than the Western Isles, but that is another matter.

You have been monitoring the budget for this year. Are you satisfied that the board now has it under control and is moving towards a break-even position by the end of the year?

Kevin Woods: I will ask Mr Smith to comment on that in a moment. My answer is in three parts. We are encouraged by the progress that has been made in recent times. We feel that the new chair, Mr Turner, and colleagues are getting to grips with the in-year position. We are cautious, but we have growing confidence as the year progresses that the board will achieve that break-even position. We intend to work closely with the board to ensure that we do that. That is the first part of our approach.

The second part is to ensure that we achieve recurring balance as quickly as possible. In other boards, we have seen considerable improvement in the past three years or so. Recurring balance will not be achieved this year, and we want to engage with the board on how the issue will be addressed.

Finally, there is the question of how we tackle the accumulated deficit. We intend to address the three issues one at a time.

Alex Smith: We have been encouraged by the progress that has been made almost month by month, which clearly demonstrates that a turnaround has taken place. As you indicated, convener, it is undoubtedly the case that the current management must deal with a very challenging position. However, we see that clear actions are now being taken and that there is clear delivery. I am cautiously optimistic that, for the first time in six years, an in-year break-even position will be delivered. I agree with Dr Woods that achieving sustainable balance is also a challenge. There is clear overdependence on non-recurring sources of funding, but that is an issue for health boards in other parts of Scotland, as well as Western Isles NHS Board. Over the past year or two, good progress has been made towards addressing the issue. In Western Isles NHS Board, in particular, improvement is beginning to come through. I am cautiously optimistic about the next financial year. It will be terribly important for us to make an assessment at the beginning of the year and to continue to do so on a monthly basis.

George Foulkes: Dr Woods referred to the accumulated deficit. If the board breaks even at the end of the year, if it comes up with a financial plan for the future that is acceptable and approved by the Executive, as we will ask it to do, and if it has a clear clinical strategy that is acceptable, will you want to burden it with having to pay off the accumulated debt? Will there not be an argument for writing off the debt, in whole or in part?

Kevin Woods: Our key priority is to get in-year balance, but I understand that there is concern about the legacy that must be resolved. In general, NHS Scotland's approach is to achieve that through a process of brokerage, because we think that it is important that debts are cleared from the places where they arise. In anticipation of a supplementary question that I may be asked, I note that on one occasion we wrote off a considerable historical debt, in the context of a board's abolition. In that case, the cumulative deficit had reached £80 million and the situation for the successor boards was clearly impossible. In general, however, our approach is to provide brokerage and to ensure repayment over time. It would be premature of me to say exactly how we may approach the issue if we end up in the situation that the member describes, but on other occasions in the past we have taken the approach that I have outlined. Ministers have made it clear that they wish Western Isles NHS Board to continue and that they have no intention of abolishing it.

The Temporary Convener: I do not have a figure for 2002-03, so I presume that the board was in balance in that year. However, in 2003-04 it was in deficit by almost £0.5 million. The deficit then rose to £1.7 million. Clearly, this was a gathering storm. It bothers me that any overspend on RRL was deducted from the next year's budget. In 2005, when the big increase took place, there was also a breach of the regulations as set out in the "Scottish Public Finance Manual". The committee has come across another example of officials not knowing what is in the manual. Why was there not earlier intervention, when it is clear that there was a gathering storm of increasing debt?

Alex Smith: Are you referring to 2005-06, the year with the £1.7 million deficit?

The Temporary Convener: Yes. The year after that, the figure was half that. Clearly, there was

financial turmoil, which can be no good for any organisation.

Alex Smith: Your first question was about 2002-03. For the record, there was an in-year deficit in 2002-03, but the reason for the cumulative position being in surplus was a carry-forward from a previous year, when there had been a surplus of just over £500,000. There was an in-year deficit in 2002-03, 2003-04 and 2004-05—you are absolutely correct about that.

As far as the £1.7 million in-year deficit in 2005-06 is concerned, true and fair accounts were presented, and there were no regulatory issues that year. However, you refer to an error that was discovered in the course of the year around the recording of savings. That was a very significant issue, which had led, I think, to an overoptimistic expectation for the year end.

The Temporary Convener: That is frightening. How can that be picked up? How can that be dealt with? I presume that such a situation could not arise again, elsewhere in the country, could it?

Alex Smith: Such things are very rare.

The Temporary Convener: How can we stop that in its tracks?

Alex Smith: That is a very rare occurrence in Scotland. During my period in this role, I have not seen another example of the same situation.

At that point, a new finance director was taking steps to address some internal control issues that had been raised by Audit Scotland, as well as some operational financial management issues. There is no doubt that a very serious error occurred. We are satisfied that the management after that point took steps to address that management failing. You can see that the position improved thereafter.

Alasdair Allan: I will not ask you to comment on the merits or otherwise of Dick Manson being appointed, but are you confident that the system that was used at the time of his appointment was robust? Was the appointment handled appropriately?

Kevin Woods: I have a little difficulty in answering your question, because I was not around at the time and do not know all the details. However, from what I understand, I have no reason to believe that the procedure was not properly followed, as far as we can ascertain.

Alasdair Allan: This might be answered by Mr Smith or others, but would you say that, at any stage, the Government or civil service formed the view that the leadership of the health board had reached a point at which it might be described as dysfunctional? If so, at what stage?

Kevin Woods: We were obviously very concerned at the way in which events in the Western Isles had unfolded. It is not the way that we would like things to be in NHS Scotland, and I am very pleased to say that, by and large, the health service is in a completely different place compared with some of the things that we have seen here. It is important to bear that in mind.

In 2005, when some of the significant financial problems were evident and some of the tensions around staff governance were apparent, we—that is, officials—made a careful appraisal of the situation here. We reflected quite hard on what action might be appropriate. As a result, we pursued a number of issues through the annual review meeting. The minister at the time was Mr Kerr. If the committee has not seen it, it might find it helpful to look at the annual review letter from that year. It sets out clearly the minister's desire for significant improvement in a number of areas, including financial management, financial control and the delivery of the recovery plan. It addresses staff governance issues and calls on the board to work collectively.

Regrettably, the situation did not improve in the following months. We continued to keep events under close scrutiny. By the middle of 2006, things had deteriorated to such a point that, when Mr Currie decided to resign, the minister decided to deploy a support force. We have been keeping the situation closely under review for some time. Of course, putting in a support force was a significant step. In general, we want to ensure the effective functioning of local NHS boards. Our approach between 2005 and early 2006 was to try to provide as much practical support and help as we possibly could.

14:00

Alasdair Allan: You mentioned the review that took place a year ago, when Mr Kerr came to Stornoway. One of the great tensions in the health board was the feeling among staff that, to move on effectively, they needed to know what was happening. Would it have been helpful if more facts had been put into the public domain at that time about the point that the relationship between national and local health authorities had reached? Was the information that was put out adequate?

Kevin Woods: I am not entirely sure what additional information you are referring to. Many of the problems in the Western Isles have been well rehearsed in the public domain. There were open exchanges in the annual review meeting and the meetings with the partnership forum, the clinical forum and so on. It has been well known that ministers and I wanted to secure improvements.

The Temporary Convener: We move on to questions about leadership and management.

Willie Coffey: As George Foulkes mentioned a moment ago, the report is the third consecutive section 22 report on Western Isles NHS Board. Some of the comments from you and your colleague are encouraging, but what is the nature and basis of your new-found optimism about the new management team? Is it evidence based? We like the forecast zero outturn for the current year, but can we rely on it? What additional evidence have you been presented with to assure you and the public that there will be such an outturn?

Secondly, in your qualified opinion, is the board heading for a fourth section 22 report, or will it avoid that?

Kevin Woods: I sincerely hope that we are not heading for a fourth section 22 report. We are determined to avoid that, but that rests on the whole board taking some important decisions. That brings me to your comments on leadership. In my view, what is needed is not just strong leadership by John Turner and John Angus Mackay, who have been doing a very good job, but determined leadership by the whole board—the executive members, the non-executive members and the stakeholder members. It requires effective working through the partnership systems that we have in NHS Scotland, and it will involve working with the public and patients who use services here in the Western Isles.

We have been sending the message for some time that the leadership challenge is a challenge for the whole board, and we believe that we are beginning to see evidence of the right approach. I was careful to express some caution in saying that we might achieve an in-year balance, but, as I said, we are optimistic about that. We have a growing confidence, and we will do all that we can to achieve it.

Willie Coffey: Is that based on evidence and not just on your belief and hope?

Kevin Woods: It is not based on hope, although I am hopeful. Mr Smith explained the processes that we go through, and I think that we are beginning to see the kind of detail that has to underpin things. The reason why, on occasion, we were not prepared to accept some of the proposals is that we were not satisfied that the detail was there. Mr Smith might want to amplify that.

Alex Smith: Continuity of senior management is extremely important, as is the working relationship between the chief executive and the director of finance. That has to be well-developed and embedded in the organisation. Their working relationship with the rest of the board on the issue of financial corporate governance is another key factor, as Dr Woods has said. I believe that improvements in corporate governance within the board will be demonstrated. We will watch closely how the board and its committees operate. There will be a particular focus on the way in which Western Isles NHS Board's audit committee operates in future. We will look for evidence of that committee developing and working well. Of course, the final evidence will be the bottom line.

The Temporary Convener: Derek Brownlee will ask about the financial recovery plan.

Derek Brownlee: In response to George Foulkes's questions on the cumulative deficit, you touched on the department's general policy and also discussed how you might approach the cumulative deficit once balance has been achieved on an in-year basis. When you consider how to reduce or wipe out the cumulative deficit, how much of a factor is the maintenance of service provision?

Kevin Woods: We want to ensure that clinical services are retained and maintained. As we work through the process, we want to achieve savings at the same time as retaining the clinical services that the people of the Western Isles require. We have made that plain.

As we have seen in other parts of NHS Scotland, it is possible to achieve improvements in financial performance through service redesign and through thinking afresh about how to provide services. That will be challenging, but it is how we can achieve savings and retain the services.

Derek Brownlee: NHS Western Isles will be expected to repay, at least in part, some of the cumulative deficit, but it will therefore be impossible to maintain the existing method of service provision. However, a different method of service provision might lead to the same outcomes. Is that what you are hinting?

Kevin Woods: If we approach—and I stress "if"—the question of an accumulated deficit through the brokerage that I have referred to, that would give us some headroom or breathing space for the detailed work of re-engineering and redesigning services to make them more cost effective.

Derek Brownlee: Service redesign often carries costs, at least in the short term. If funding to the Western Isles is sufficient for the current level of services, repaying part of the cumulative deficit through a redesign will not be possible if services are to be maintained at precisely their current level. If that were possible, could it not be argued that the current level of funding is excessive?

Kevin Woods: Judged using the Arbuthnott formula and the NHS Scotland resource allocation committee formula, that is indeed what is

suggested. Compared with other parts of Scotland, NHS Western Isles is getting more than its fair share of the national cake. The repayment of any accumulated deficit is, in essence, achieved by transferring resources from elsewhere to the Western Isles for that purpose, and that is an important consideration for us.

If we approached the resolution of the deficit through brokerage, we would want to improve efficiency and to retain the volume of services while doing things in a more cost-effective way. That has been achieved in a number of places.

As the convener will know from previous meetings of the Audit Committee, I have on occasion explained the central resources that support our work on redesign.

We have an improvement and support team in our delivery directorate, which provides practical help and support to boards as they address such matters, and we are engaged in important nationally sponsored work on benchmarking and cost-effectiveness comparisons. We share information all the time with the service as a practical way of helping people to address such matters.

There are important additional dimensions. We have done national work on the future pattern of remote and rural health services, which is currently with ministers and will be responded to in the spring. That work will be extremely important in helping boards such as Western Isles NHS Board to address the difficult issues that they face, which we do not underestimate. There has been a gap in strategic thinking on such issues, which is why a major piece of work has been produced. I am pleased to say that Paul Martin, who is here in a slightly different capacity, has been central to that work, and I am sure that he will be pleased to tell the committee about the thinking behind it. The work is important because it can help Western Isles NHS Board to develop its clinical strategy. That strategy ought to be the context in which what I have said about service redesign takes place. As well as financial recovery, a key issue for us is bringing together a sound and coherent clinical strategy, the financial strategy and a workforce strategy, and we hope to achieve that. Our work on remote and rural areas services should help the board to think through how that can be done.

Paul Martin (Scottish Government Health Workforce Directorate): I reaffirm the importance of a clinical strategy—my other day job is chief nursing officer for Scotland. A robust clinical strategy must recognise the financial arrangements and situations in which the strategy has to be delivered. A clinical strategy that ignores those arrangements and creates unsustainable or unaffordable services will not be good. The point that has been made is therefore right, if I understood what was said correctly.

On the future direction of remote and rural services, not only the island communities, but parts of mainland Scotland—the Borders, Dumfries and Galloway and the Highlands—have clearly come together over the past year or so to identify the challenges relating to sustainability in delivering services in remote and rural communities and how such services can respond to changing clinical demands, changing demography and changing technology, which can be both a help and a hindrance. In the work that we have done in partnership with several stakeholders, we have considered, for example, defining what a remote and rural general hospital could look like, what could be expected of it, the core services that local communities could expect from such hospitals and the core services that it would be reasonably safe to deliver in and around them. Workforce challenges and the competencies that are required of a workforce that works in and around remote and rural services, which can be quite different from those that are required elsewhere, have also been considered. As members will readily appreciate, the skills that are required of a doctor, nurse or physiotherapist who works in a local hospital can be different from those that are required by a doctor, nurse or physiotherapist who works in Glasgow royal infirmary. The report that the department is currently considering captures such matters and plays them into the process. As Dr Woods said, we hope to feed back our responses to it in the spring.

Derek Brownlee: Aspects of previous recovery plans have been mentioned—I think that Kevin Woods said that previous recovery plans were challenged. Are you comfortable that the aims of the current recovery plan are attainable, as opposed to being comfortable that they will definitely be delivered?

14:15

Kevin Woods: I will in a sense repeat what I have said before: we are cautiously optimistic. We believe that some of the steps that are being taken are more deliverable than some of the previous proposals. Mr Smith may want to comment on some specific details, particularly in relation to changes in the flow of resources between the board and other boards in NHS Scotland.

Alex Smith: In essence, the question was why we should believe the most recent financial recovery plan. The reason why we can be more assured about its delivery is the work that we have seen in the past few months and the quality of the reporting and evidence to back it up. A key issue will be the one that Dr Woods and Mr Martin

picked up about the change programme, which the committee has been exploring. The two must work together: the change programme will evidence the financial recovery plan and the actions that we take around it. However, the documentation that we are seeing and the approach that is being taken lead us to be more assured. The work to which I referred earlier and the engagement of and support by the full board will be absolutely key.

Stuart McMillan: Has NHS Western Isles submitted any requests for extra funding in the past five years?

Kevin Woods: I am not aware of any specific requests for additional funding. We frequently get representations from people who would prefer the resource allocation formula to work differently. One could certainly count those as requests for additional funding. However, to answer the question as it was posed, I am not aware of a specific request, although perhaps Mr Smith is.

Alex Smith: No, I am not. The allocation arrangements are clear. When a chief executive receives the resource limit for the year, they accept that they will deliver within that available funding. We have not had such a request. Dr Woods is absolutely right that an opportunity to influence the funding mechanism would be the appropriate way in which to deal with that issue.

Kevin Woods: One point needs to be brought out in relation to requests. We make non-recurring allocations to boards beyond the recurring allocations, and some of those may derive from a dialogue that we have with boards.

Stuart McMillan: So, in essence, despite the increase in the health board's budget deficit in the past five years or so, it did not go to the then Scottish Executive to ask for additional funding to try to reduce the debt that had accrued. Is that correct?

Kevin Woods: I am not aware of representations being made to us in those terms. In any case, the answer would have been that we make allocations in accordance with ministerial policy about the implementation of the Arbuthnott formula.

Stuart McMillan: I have a more general question. What action could you and do you take if an NHS board calls down more funding than it has already been allocated?

Alex Smith: The board is not in a position to do that. However, we could say, "Hold on a minute, we have a demonstration here that the board has exceeded its allocation." Obviously, that issue is discussed with the health directorates—there is a managed process. We have accepted that there is an overspend, and funding has been made available to ensure that the money matches the requirement. However, we require a financial recovery plan, to ensure that the overspend will be replaced in due course. That type of engagement is required when such events happen.

George Foulkes: I have a question that arises from one that has just been answered. I think that Alex Smith said that, when a chief executive accepts the resource limit, he agrees to deliver within that. What happens if the chief executive does not accept the resource limit?

Alex Smith: He would not be able to deliver, which is his job.

George Foulkes: Yes, but then the question is irrelevant. Is he able to say, "I don't accept that resource limit"?

Kevin Woods: Effectively, no.

George Foulkes: In other words, he is simply told how much he is going to get.

Kevin Woods: Yes, but let us be clear: this is not an arbitrary decision; it is informed by the application of a detailed and thorough evidence-based formula that determines what the fair share of the NHS cake should be. It has been a long-standing policy of successive Governments to move progressively towards ensuring that boards get their fair share of that cake through a process of levelling up, rather than a process of levelling down. The current cabinet secretary has made it clear that, as she approaches the question of implementing the revised formula, that process will be achieved by levelling up.

George Foulkes: I understand that completely. When I represented Ayrshire, I thought that the Arbuthnott formula was wonderful. However, now that I represent the Lothians, I am not so sure. It is a question of swings and roundabouts. However, that is not what I am asking about.

The implication is that the chief executive accepts the resource limit and says, therefore, that he can deliver. However, that is not the case because, in fact, he is given the resource limit and is required to accept it. Am I correct?

Kevin Woods: Yes, but there is also a parallel process, which is called the local delivery plan, which involves our agreeing with boards the levels of service that they will achieve with the resources that they have in the year in question. There are two components to the annual agreement that we make with the boards. One is about service performance, which involves a high level of detail, and the other concerns the financial plan, which relates to the point that Mr Smith is trying to make.

I would like to make two other points. The first is that I think that NRAC might suggest a favourable improvement in NHS Lothian's financial position. The other point is that, as I said earlier, the budget

of NHS Western Isles has been increasing by 6.7 per cent, on average, over the last three years.

The Temporary Convener: We have now reached the final part of today's proceedings. I want to ask three specific questions.

Why did the board not agree corporate objectives in 2006-07 and what action was taken in relation to that?

Kevin Woods: I noted that the Audit Scotland letter to the board commented on corporate objectives and I understand why it did. However, a narrow interpretation of what a corporate objective is may have been used. In that year, the board had to address everything that we had agreed in the local delivery plan, which contained a set of precise agreements to carry forward policies that were agreed between us—to that extent, those were objectives. Of course, there are also internal objectives that the board sets for itself. A lot of those derive from the audit reports. Further, following the annual reviews, we have been clear with all boards about the actions that we want them to take.

I take the point that is made, but there might be an issue relating to the precise understanding of what a corporate objective is. I know that Mr Turner's immediate predecessor eventually captured some of that more succinctly in a single paper. I do not want to leave the committee with the impression that there had not been a dialogue about what the board's objectives should be.

The Temporary Convener: Can you assure us that there has been a meeting of minds?

Kevin Woods: As I said, the key dynamic, from our point of view, is the local delivery plan. We have been happy to agree some of the service delivery objectives, but we have not been happy with some of the financial dimensions. We have wanted to be convinced that the financial proposals can be delivered.

The Temporary Convener: How long will it take to get satisfaction?

Kevin Woods: Do you mean satisfaction on the financial issues?

The Temporary Convener: Yes.

Kevin Woods: The first thing on which we hope to get satisfaction is in-year balance.

The Temporary Convener: What about corporate objectives?

Kevin Woods: We are about to issue detailed guidance to boards about delivery plans for next year. Between now and the start of the financial year, we will want to agree the specific proposals for 2008-09. We will be carrying out that process again, as we do annually, in the next few weeks.

The Temporary Convener: How are you monitoring the performance of NHS Western Isles?

Kevin Woods: That process is led from within the part of the organisation in which Alistair Brown works. We have a delivery group, which holds regular meetings, the HEAT system and a series of indicators that capture ministers' key priorities. I am sorry that my answer is a bit jargonistic, but we have performance trajectories for each of those. Dialogue is on-going between the delivery group and individual boards. There are similar arrangements for financial reporting.

If we are not happy about what is being reported to us, we have an escalation process, which is intended to ensure that we seize and deal with issues early on. In 2007, we were concerned about whether some things would be delivered. That matter was escalated to me and I came to the Western Isles in July to address some of the issues with the board. The process is routine, but escalation steps are built into it.

The Temporary Convener: You have given us wide-ranging replies. Are you sure that you know why NHS Western Isles got into its current situation and that your own performance arrangements are properly applied?

Kevin Woods: There are two or three things to say in response to that. You have probably seen from audit letters in recent years that there has been a weakness in internal controls. That is clear from the Audit Scotland report. We have seen recent improvements, but we need to ensure that all those matters are finally addressed, bearing in mind that risk management is a complex and on-going business.

On the non-delivery of financial recovery in 2005-06 and so on—I need to be careful about my dates—it is true that, at the time, the governance difficulties that were evident in the board were central and were getting in the way of the delivery of financial balance. That is why we set such store by restoring effective governance in the board.

Finally, there is the issue of the board's performance management regime. All boards need an effective process of internal performance management. I understand that there have been recent changes in personnel in the board, which are intended to bring that about. That is important.

George Foulkes: What role did Deloitte play in all this?

Kevin Woods: I think that Deloitte was the board's internal auditor.

George Foulkes: During all this time?

Kevin Woods: I defer to Mr Smith, who might know more about that than I do.

Alex Smith: Deloitte was the internal auditor in recent times, but I do not know exactly how far back its engagement goes—I do not have the exact date for that. It conducted the internal audit for NHS Western Isles.

George Foulkes: Did it communicate with you?

Alex Smith: The internal audit is for the board. There is a distinction between the external audit role and the internal audit role.

George Foulkes: So, the internal auditor does not communicate with you, but the external auditor does.

Alex Smith: It would be most unusual for the internal auditor to communicate with us. That is not normal.

The Temporary Convener: We have reached the end of this evidence session, in which we have discussed important issues that affect us all. We have now seen the process of Parliament questioning officials who are responsible for running on our behalf the services that affect every one of us. Today's procedures are part of a longer process. The Audit Committee will now consider the evidence and discuss what further steps it will take. We will consider in detail the evidence from all our witnesses, which is appreciated. I thank all the witnesses for their contribution to the inquiry. MSPs and members of the public have seen the scrutiny that can take place of the officials who are entrusted with running our public services. We will produce a report, which will be available to the public. The committee thanks everyone who has participated. We will consider the evidence taken today at our meeting on 23 January, when we will discuss the next steps for the inquiry.

Meeting closed at 14:30.

Members who would like a printed copy of the *Official Report* to be forwarded to them should give notice at the Document Supply Centre.

No proofs of the *Official Report* can be supplied. Members who want to suggest corrections for the archive edition should mark them clearly in the daily edition, and send it to the Official Report, Scottish Parliament, Edinburgh EH99 1SP. Suggested corrections in any other form cannot be accepted.

The deadline for corrections to this edition is:

Monday 21 January 2008

PRICES AND SUBSCRIPTION RATES

OFFICIAL REPORT daily editions

Single copies: £5.00
Meetings of the Parliament annual subscriptions: £350.00

The archive edition of the *Official Report* of meetings of the Parliament, written answers and public meetings of committees will be published on CD-ROM.

WRITTEN ANSWERS TO PARLIAMENTARY QUESTIONS weekly compilation

Single copies: £3.75
Annual subscriptions: £150.00

Standing orders will be accepted at Document Supply.

Published in Edinburgh by RR Donnelley and available from:

Blackwell's Bookshop

53 South Bridge
Edinburgh EH1 1YS
0131 622 8222

Blackwell's Bookshops:
243-244 High Holborn
London WC1 7DZ
Tel 020 7831 9501

All trade orders for Scottish Parliament documents should be placed through Blackwell's Edinburgh.

Blackwell's Scottish Parliament Documentation Helpline may be able to assist with additional information on publications of or about the Scottish Parliament, their availability and cost:

Telephone orders and inquiries
0131 622 8283 or
0131 622 8258

Fax orders
0131 557 8149

E-mail orders
business.edinburgh@blackwell.co.uk

Subscriptions & Standing Orders
business.edinburgh@blackwell.co.uk

Scottish Parliament

RNID Typetalk calls welcome on
18001 0131 348 5000
Textphone 0845 270 0152

sp.info@scottish.parliament.uk

All documents are available on the Scottish Parliament website at:

www.scottish.parliament.uk

Accredited Agents
(see Yellow Pages)

and through good booksellers

Printed in Scotland by RR Donnelley