AUDIT COMMITTEE

Wednesday 27 February 2008

Session 3

£5.00

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

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AUDIT COMMITTEE
4th 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:

Mr Robert Black (Auditor General for Scotland)
Russell Frith (Audit Scotland)

THE FOLLOWING GAVE EVIDENCE:

David Currie
Dick Manson

CLERK TO THE COMMITTEE

Tracey Reilly

SENIOR ASSISTANT CLERK

Joanna Hardy

ASSISTANT CLERK

Rebecca Lamb

LOCATION

Committee Room 2

Scottish Parliament

Audit Committee

Wednesday 27 February 2008

[THE CONVENER *opened the meeting at 10:00*]

Decision on Taking Business in Private

The Convener (Hugh Henry): Good morning and welcome to the fourth meeting in 2008 of the Audit Committee. Under agenda item 1, do members agree to take item 5 in private?

Members *indicated agreement*.

Section 22 Report

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

10:01

The Convener: We move to agenda item 2. I welcome David Currie and Dick Manson, who are here for our inquiry into NHS Western Isles. Does either of you wish to make a preliminary statement?

David Currie: Yes.

Dick Manson: Yes, please.

The Convener: We will hear from you in alphabetical order: Mr Currie is first.

David Currie: Thanks very much for the invitation to appear before the committee today.

In all controversies, a lot depends on where the tale begins. The problems in NHS Western Isles go back a long way, and the underlying causes of those problems must be understood before any solutions will be found. There have been a lot of good intentions along the way, and some well-meaning decisions and actions in the past have had unintended consequences.

Attempts to address problems have been frustrated by fundamental difficulties. First, I highlight geography. It will always be more expensive to deliver health care in the islands as a cost per head of population. That fact has to be accepted and acknowledged. There has perhaps been a tendency to use remote location as a legitimate reason for incurring additional cost and expecting that cost to be accepted by the Health Department.

Secondly, I highlight infrastructure. The two main hospitals in the Western Isles are excellent facilities that enable a very high standard of secondary care to be delivered. However, those resources are underutilised and, if we were designing the most appropriate facilities and services for the islands today, they would look very different. The Stornoway hospital, in particular, has contributed to a certain mindset around building up as big a range of services as possible, which requires a concentration of resource in that hospital. It is important to find the right balance between primary and secondary care.

I move on to the lack of management capacity and capability. With a small local pool and a lower rate of churn, recruiting the right level of skills, experience and attitude has always been, and perhaps always will be, a problem. In the past, there was a tendency for people to be recruited

into managerial roles on the basis of relationships, which led to confused priorities. Allied to that is the fact that issues tend to become politicised and personalised in the islands, which makes it more difficult to address the fundamentals.

When I joined Western Isles Health Board, I found a disconnect with NHS Scotland, particularly at management level, and a lack of understanding or engagement with the national health service agenda. There was a strong perception that financial balance was not an issue and that the health board would always be bailed out at the end of the day.

Against all that, and through all the difficulties, staff at the coalface have continued to deliver an excellent standard of service. There are some very good people in NHS Western Isles, who are committed to solving problems and who want progress.

Dick Manson: I was interim chief executive and then chief executive at NHS Western Isles from late May 2003 until August 2006. I would like to set out some context about the 2006-07 financial position of the board. NHS Western Isles is a small board in a remote location, as you know. In the past, it has invested heavily in developing consultant-led services, unlike the other island boards. NHS Western Isles has a history of living beyond its means. In the past, it has used capital-to-revenue transfers; it has also used ring-fenced money to try to balance its revenue position.

The overspend has been brought into focus more sharply in recent years, as the European working time directive forced the board to end some of its clinical practices. For example, the board used to have quite a number of single-handed consultants, who were on call 24 hours a day every day of the year. That is no longer possible. Bringing an end to such practices has cost the board a lot of money; it has made its current services unsustainable in their present form and, from a resource point of view, unaffordable.

The board has been trying to tackle the situation, but it has been hampered in its attempt to come back into balance, because it has not been able to change the models of care in time to absorb the other cost pressures that have come into the system, such as pay modernisation and the cost of medical out-of-hours services. My view is that it has also been hampered by the high turnover of chief executives. I was the seventh chief executive in 10 years and there have now been 10 in just over 12 years. That lack of continuity makes it difficult to keep the appropriate systems up to date and effective, so financial, human resources and procurement systems have had to be developed and implemented time and again.

In addition, the lack of management capacity and development opportunities for all staff and board members in a small board is a major challenge in trying to make the necessary changes. NHS Scotland has not yet developed ways of providing support for smaller boards to enable them to benefit from the capacity and expertise of the larger boards. That issue requires to be addressed further.

I supplied some written material for the committee by way of context. I am happy to answer questions on it or on any other issue.

The Convener: Thank you very much.

George Foulkes (Lothians) (Lab): I have a question on your opening statement, Mr Currie. You are not from the Western Isles, are you?

David Currie: No, I am not.

George Foulkes: How did you come to be appointed chair of the Western Isles Health Board?

David Currie: I had lived in the Western Isles for about 10 years and was manager of the Royal Bank of Scotland there. I was appointed as a non-executive director and then the opportunity for the chairman's post came up. I applied for it and was successful in the interview.

George Foulkes: Was Mr Manson appointed chief executive while you were chairman?

David Currie: Yes. He was appointed about 18 months or two years after I had taken up the role of chair.

George Foulkes: He was interim chief executive first, was he not?

David Currie: Yes, he was.

George Foulkes: Did you choose him to be interim chief executive?

David Currie: No. I had asked the Scottish Executive Health Department for assistance. The chief executive was off ill at the time, and the SEHD sent up Mr Manson as interim chief executive.

George Foulkes: Did the board then appoint him permanently? Was it a board decision?

David Currie: Yes, it was. A vacancy became available and there was an appointment process. A number of candidates were interviewed and Mr Manson was the successful candidate.

George Foulkes: Why did you demit office as chair of the board?

David Currie: I resigned in July or August 2006. I had been in post for five years and felt that I had probably taken the role as far as it could go. There were a number of difficulties. Quite an intense

media campaign was running and the agenda had become more political. With an election coming up nine months down the road, I felt that I would be unable to take matters forward in such a political environment and that it was probably better if someone else came in, given the extent of the media coverage that there had been.

George Foulkes: Mr Manson, why did you leave immediately afterwards?

Dick Manson: Like Mr Currie, I felt that it was time to leave and that there was an opportunity to give the board fresh leadership. I had served just over three years as chief executive; those were a stressful three years, so I felt that it was time for me to move on to something else.

George Foulkes: It was nothing to do with the accumulated deficit.

Dick Manson: No. At that time, the forecast was that the board would come back into financial balance in 2006-07 and would be able to address its accumulated deficit in future years.

Jim Hume (South of Scotland) (LD): You both say that you thought that it was better for the board that you move on. However, an interim chair and an interim chief executive took over your positions afterwards, and I would have thought that, in most boards, a chair or chief executive would stay until a permanent chair or chief executive had taken up the post.

Dick Manson: An opportunity for me to move simply arose. As an NHS manager, I can only pursue the opportunities that exist, so I simply pursued the opportunity and was able to be released for it.

Jim Hume: So it was more about personal development.

Dick Manson: There was something available, I applied for it and moved to it on secondment.

The Convener: What opportunity did you move to?

Dick Manson: Director of national development projects in NSS.

The Convener: Is that in St Andrew's house?

Dick Manson: No, it is in NHS National Services Scotland; I am based in Glasgow.

Andrew Welsh (Angus) (SNP): Mr Manson said that he was the seventh chief executive officer in 10 years. Is that true?

Dick Manson: Yes.

Andrew Welsh: It has been put to me that there were three before you. One served for two years, one for four years and one for six years, making a total of 12 years. Who is right?

Dick Manson: When I arrived, I was told by the senior staff that I was the seventh chief executive in 10 years. I cannot name them, but the staff named for me six predecessors.

Andrew Welsh: If there were six predecessors, that indicates a great turnover.

Dick Manson: Indeed.

Andrew Welsh: Did you not feel that you should check whether the figure was correct?

Dick Manson: I am simply relaying to the committee the facts that were relayed to me.

Andrew Welsh: Would it surprise you to hear that the figure appears not to be correct? In fact, there were only three predecessors. Why were you told that there were six?

Dick Manson: The director of nursing and the medical director were able to go through my predecessors by name. Jane Adams, the nursing director, told me that she had been there 10 years and she named my six predecessors.

The Convener: I want to explore the particular skills that Trevor Jones felt you would bring to a situation that was clearly difficult. What was your post before you were appointed as interim chief executive?

Dick Manson: I was projects director in the Scottish Executive Health Department.

The Convener: How long had you been there?

Dick Manson: Just over two years.

The Convener: Where were you before that?

Dick Manson: I was the chief executive on the board at the state hospital in Carstairs.

The Convener: Why did you move from Carstairs to the post as projects director? Was it a career opportunity, or was anything else involved?

Dick Manson: It was a career development opportunity. I had been at the state hospital for 10 and a half years and I had stayed on at the request of the Health Department and Trevor Jones.

The Convener: Was it anything to do with management issues at Carstairs that led to your moving to the Health Department headquarters?

Dick Manson: As you know, Carstairs is always a difficult place to run and manage. There are always difficulties, particularly in getting the balance just right between security and care. That raises lots of passions among staff on both sides of the debate.

The Convener: Had the project development post that you moved to been advertised before you applied for it?

Dick Manson: No. It was a development opportunity that Trevor Jones offered me in exchange for having stayed on at the state hospital. It was arranged with his predecessor as well.

Andrew Welsh: Is there any truth in the statement that you faced a vote of no confidence at Carstairs?

Dick Manson: During my time at Carstairs, when I was promoting change and forcing it through, votes of no confidence were threatened on several occasions. However, there were no votes of no confidence during my time there.

George Foulkes: Did you stay in the Western Isles when you were chief executive?

Dick Manson: No.

George Foulkes: Why not?

Dick Manson: Initially, I was there on secondment, so—

George Foulkes: Yes, but secondees can move. You were there for three years.

Dick Manson: The secondment was initially for three months. I was asked by Trevor Jones to go to the Western Isles for a secondment of about three months to support the board while the chief executive was off sick.

George Foulkes: Then, as Mr Currie told us, you were appointed permanently by the board. I presume that the appointment was made for the foreseeable future at the time. Why did you not move to the Western Isles?

Dick Manson: For family reasons. I was up front with the board about that. I felt that I could not move my family to the Western Isles. If that had made me unappointable in the board's view, I would have been happy to step back.

George Foulkes: Did you fly from Glasgow up to Stornoway every week?

Dick Manson: Yes, I commuted weekly.

George Foulkes: Did the board cover the cost of that?

Dick Manson: The board covered the cost, although the majority of the costs were able to be worked round mainland meetings.

George Foulkes: I am sorry, I did not catch that.

Dick Manson: The majority of the costs of my travel to and from the mainland were able to be covered round NHS Scotland meetings on the mainland. Most senior staff at director level in the Western Isles Health Board, and in the other island health boards, are required to go to NHS Scotland meetings on the mainland fairly regularly—certainly weekly, and sometimes twice weekly.

10:15

George Foulkes: Were you in the Western Isles on most weekdays—Monday, Tuesday, Wednesday, Thursday and Friday?

Dick Manson: On most weekdays, yes.

The Convener: You made an arrangement with the board, and on some days there was NHS business, which helped to facilitate that. Once you had the substantive appointment, did the board continue to pay for your travel from Glasgow to the Western Isles?

Dick Manson: Yes.

The Convener: When someone makes a decision to move to a substantive post, is it not unusual that their travel expenses continue to be funded? Mr Currie, you were the chair at the time. Did you consider that arrangement and decide that it was appropriate?

David Currie: Yes. As I mentioned in my opening statement, we have a very small local pool. It is inevitable that we have to attract people from outside to get the right level of skills and experience. Living in the Western Isles does not always suit the family circumstances of those individuals. There is no way round that.

The Convener: Is it within the competence of the board to do that? Was it within the board's means?

David Currie: It was—we can move to financial matters later. It was within the board's means, and I believe that it was within the competence—and certainly with the full knowledge—of the Health Department. People commuting in and out of the Western Isles is a very common scenario.

The Convener: We move on to governance arrangements and systems of internal control.

Andrew Welsh: Mr Manson, you stated that when you arrived in 2003 there were problems in finance, human relations practice, governance, clinical governance, in relations within and outwith the organisation and in management. What caused NHS Western Isles to move into a cumulative financial deficit in 2003-04?

Dick Manson: The main elements in relation to the financial deficit in 2003-04 were the implications of the European working time directive. The health board had a number of single-handed consultants, for example in paediatrics, and as people retired from those posts—which are quite onerous, as they were on call 24 hours a day, every day of the year—the

board was unable to continue that practice and had to make arrangements for locum cover.

That year, there was a very high locum cover cost of around £1 million. A number of staff were also added to the payroll for various initiatives during that year. A number of centrally funded initiatives were no longer to be centrally funded, and the cost had to be picked up by the board. When I arrived at the end of May, the board was projecting a £1.2 million deficit for the financial year 2003-04, and it had submitted a financial recovery plan to the Scottish Executive Health Department with regard to that.

Andrew Welsh: You arrived, and you were immediately faced with the major problem of an estimated £1.2 million deficit. What did you do to turn that round?

Dick Manson: The main focus was on trying to ensure that controls were in place; that where we had opportunities to save money—with vacant posts, for example—we took advantage of that; and that we reduced unnecessary spending on things such as supplies and maintenance projects, which could perhaps be deferred to future years.

We considered very carefully how we could save money on locum cover. Locum cover in the Western Isles is very difficult because the place is remote and it is not easy to attract consultants to come and work there. Western Isles Health Board had found that it had to rely on agency locums, who were paid at very high rates. We put a lot of effort into trying to get locums to come and work in the Western Isles at NHS rates.

Andrew Welsh: Was that adequate to stop a £1.2 million potential deficit?

Dick Manson: It brought it down in that year. We were forecasting break-even, and in the event I think that it came in at about £295,000 over, of which around £250,000 was an adjustment from the previous year's accounts that the external auditors asked for.

Andrew Welsh: Did the action that you took address any of the underlying problems rather than the surface problems?

Dick Manson: No, it did not.

I will outline the underlying problems. There were two hospitals that were first-class facilities for the local community but which did not operate at optimum capacity. Some 30 per cent of the beds in the Western Isles hospitals were empty at any one time; consultants' productivity was fairly low; and we needed to have a minimum of three consultants in each specialty under the working time directive arrangements. There had to be three surgeons, three anaesthetists and three physicians, while the consultants' workload did not keep them fully occupied. Consultants tended to do work that other clinical staff could have done, simply because they were there and they wanted to be occupied.

I thought that the key issue was that we needed to consider redesigning the clinical services to make them more affordable and to partner up with people with expertise on the mainland, in Inverness and Glasgow, to avoid the need to have consultants on site all the time. The board agreed with me about that.

Andrew Welsh: We will consider more fundamental issues in a moment.

You were an interim chief executive. I presume that you were in the post on a temporary basis.

Dick Manson: That is right.

Andrew Welsh: In your submission, you state that the action you took on finance included producing

"a further refined recovery plan which reduced staff travel"

and establishing

"a vacancy control committee to put the brakes on staff recruitment"

and

"a strengthened audit committee to implement audit value for money recommendations".

In other words, you simply introduced a series of cuts and value-for-money measures as opposed to tackling an immense problem that affected the whole organisation. Was that approach adequate?

Dick Manson: We did two things. First, as you rightly said, we implemented several immediate measures to try to put the brakes on spending. I outlined those measures in my submission. Secondly, we tried to set up a review of clinical services—I also mentioned that in my submission. That review had been started. Before I arrived, the board had invited an academic to come to the Western Isles, review its clinical services and make proposals on progressing a review of them. I operated on two fronts. First, I took immediate action to try to rein in expenditure and put in place control mechanisms. That was prudent management. Secondly, I tried to accelerate the review of clinical services to address the underlying difficulties in the Western Isles.

Andrew Welsh: In your submission, you say that clinical services were redesigned, replanned and refocused, and that there was re-engagement. However, it is the reality that matters rather than words.

There was no finance committee. There was a finance recovery plan and a finance team, but a finance committee did not arrive until 2005. A sub-committee with staff representation arrived in 2006. Surely there should have been a finance

committee much earlier. Rather than having only a finance team to consider the massive problems that existed, a fully equipped and fully operational finance committee should have fulfilled the task at hand.

Dick Manson: The view was taken at that point that the whole of the non-executive team and the whole board should be engaged in the financial recovery process, and that financial recovery was a matter for the board rather than a matter that should be delegated to a finance committee.

The Convener: Mr Currie, as the chairman of NHS Western Isles, did you take any steps to set up a finance committee or did you think that financial recovery was the responsibility of the whole board?

David Currie: The board talked about that in considerable detail and reviewed the best way to handle matters. At that time, we thought that the board approach was better, but in 2005 we realised that a finance committee would give us a better result, and we therefore established one.

The Convener: Obviously, finance is your background—you were a bank manager. You were still in position when the 2005-06 budget was set. Did you set a budget for more money than was available to you?

David Currie: No. I set a budget that would be challenging to deliver, but I do not remember its involving more money than was available to us.

The Convener: You did not overset to the tune of £1.7 million?

Dick Manson: Not to my knowledge. I do not recall that.

The Convener: Okay. We will check whether that happened in 2006 or 2007.

Did either of you request additional funding from the Scottish Executive at any time?

Dick Manson: Yes, we did. We asked the Scottish Executive for both financial support and help from financial experts—qualified accountancy staff.

The Convener: In each of the financial years for which you were there?

Dick Manson: We asked first in 2003-04 and again in 2005-06. Although the Health Department was sympathetic regarding some of the financial challenges that we faced, we were of the view that it could not be seen to be bailing out Western Isles Health Board. It felt that the board's allocation was adequate and it was prepared to discuss brokerage that could be repaid in future years.

The Convener: So, you knew that no additional money would be forthcoming.

Dick Manson: Yes. We knew that there would be no additional money. That is correct.

Andrew Welsh: Mr Manson, can you provide any evidence that the board had, historically, spent more than its allocation before your arrival?

Dick Manson: Because I no longer work for the board, I do not have that evidence to hand, but I am sure that that information can be provided to the committee.

Andrew Welsh: The deficit rose, but you introduced these plans. Did you identify the underlying causes of the deficit? The deficit went from £495,000 in 2003-04 to £444,000 in 2004-05 and more than quadrupled to £1.746 million in 2005-06. When you introduced the initial measures, they were clearly not adequate because the accumulated deficit began to mount up.

Dick Manson: Absolutely. The main pressure that led to the £1.7 million deficit was the fact that we simply had not made good progress. Changing round clinical services is a long-term project, and we simply had not made any quick progress that would have made significant change to those services. Because of that, the board was unable to make the savings that were necessary to meet the cost pressures of pay modernisation—the medical out-of-hours service, which hit Western Isles Health Board disproportionately because of its geography. Because of the geography of the Western Isles, the board needed to have general practitioners on call in different locations in the evening, which it had to pay for. The board simply was not able to change its clinical services quickly enough to make the savings to meet those cost pressures, and that is what led to the £1.7 million deficit.

Andrew Welsh: Did you feel that the board had the confidence and expertise to overcome its massive, continuing and growing problems?

Dick Manson: I felt that we needed additional expertise in the board. As Mr Currie and I have said, the board is small and has limited management capacity. We felt that we needed additional clinical support as well as additional financial and HR support from elsewhere in NHS Scotland.

The Convener: On a similar theme, Jim Hume wants to ask about the financial position in the board's briefing.

Jim Hume: Mr Currie said that he cannot recall oversetting the budget, but there was an overset because there was a £1.75 million deficit in 2005-06. Coincidentally, you both decided to seek different careers in the middle of that year, and the board had five months of interim chairs and chief executives. Can you recall how you kept the board

briefed on the financial position, and what action it took when the position was worsening?

10:30

David Currie: Which period are you talking about?

Jim Hume: In general, how did you keep your board briefed?

David Currie: That was done through regular monthly board meetings. Finance was always high on the agenda for those meetings and was discussed in considerable detail. Once a finance committee was set up, we had executive and non-executive leads involved in that, as well as staff representation. The committee reported fully to every board meeting.

Jim Hume: Looking back, would you have handled the situation differently?

David Currie: It is difficult to say—situations evolve and change. We always recognised that solving the difficulties of Western Isles NHS Board would be a long haul. It was not going to happen overnight—it was going to take a number of years, and would require building up the governance structures and the expertise around the board table. I do not know. Hindsight is a poor counsellor.

Jim Hume: Okay, but when the position was worsening, what did you do differently? Was it just a case of doing what you did before?

David Currie: It was that, and trying to ensure that we had full engagement from the staff and an understanding of the need to monitor and manage expenditure. That is my recollection. Dick Manson perhaps has more detail.

Dick Manson: We had fortnightly discussions on finance at our executive team meetings and our board meetings. We moved to board meetings, and increased the number of such meetings per year. At every board meeting we had a discussion on the financial position and on the areas for financial recovery. We majored on trying to crack the service redesign issues and on trying to get more sustainable, and therefore more affordable, services. At that point, about 10 per cent of our staff were engaged with the public in service redesign working groups to consider how we could provide surgical, anaesthetic and maternity services and so on in the future, not only with a view to making them sustainable under the working time directive and ensuring that we had properly trained and skilled clinicians, but with a view to ensuring that we played to the strengths of the whole clinical staff rather than simply looking for an expensive consultant-led solution.

Jim Hume: Did you fully inform the board of corporate governance? Did it go through all the briefings on its responsibilities under corporate governance?

Dick Manson: We had two board away days on corporate governance issues: on the role of executive and non-executive directors, and on the role of non-executive directors in holding the executive team to account. I presented a report to the board in 2005 on how it could rebuild and improve its governance arrangements. That included clear roles, remits and outcomes for each committee; clarity about the role of the executive and non-executive directors; a clear corporate plan that set out the deliverables that were expected of NHS Western Isles and which the board should review at every meeting; and how the board should tackle issues that were raised by the auditors to do with lack of financial controls and lack of follow-through on some audit recommendations.

We asked the Scottish Executive whether it could support us with further development and training for non-executive directors to help give them more confidence, but we were unable to deliver that during that year.

Jim Hume: Did you not see that as being part of your joint roles?

Dick Manson: Yes. The chairman and I, with some colleagues who were not on the board, held two development seminars for the board, but we felt that there was a need for people to have mentors from elsewhere in the NHS—non-executive directors—to help to bring skills. We facilitated colleagues' going to other boards to see how things were done and to pair up with non-executive directors.

The Convener: For the record, the overset was for 2006-07 and not 2005-06. I apologise.

Willie Coffey (Kilmarnock and Loudoun) (SNP): Mr Manson, in your opening remarks, you said that

"NHS Western Isles Board has a history of living beyond its means."

I understand that you took up your post in May 2003. My information is that, in April 2003, no deficit was reported by the board. My question is really for both witnesses. When you left office in July or August 2006, the cumulative deficit was £2.5 million, which means that the health board went from having no deficit to having a deficit of £2.5 million just three years later. Are you asking us to accept that that deficit was entirely attributable to matters that were outwith your control? I would like both witnesses to answer.

Dick Manson: The answer is no—I am not asking people to accept that matters were entirely outwith my control. My submission tries to explain that, in the past, Western Isles NHS Board was

able to cover its revenue deficit by capital-to-revenue transfers. In 2002-03, the year that Mr Coffey mentioned, the board had used a capital-to-revenue transfer of about £0.5 million to support its revenue position and to break even. It had also used some one-off ring-fenced money from the Scottish Executive to cover its revenue position. It had done that to varying degrees in previous years. In common with other health boards, it had been able to support its revenue position with capital-to-revenue transfers.

As the ability to cover capital-to-revenue transfers began to reduce, with a view to its being phased out, the situation became difficult for the board because already its revenue allocation could not meet its revenue position. That was a challenge. Given that the vast majority of the expenditure was going on people who provide services, and that there was a low turnover, the health board was in a different position to boards elsewhere in the country that have higher rates of turnover because there are more jobs so people can move around.

The board started from the base of not living within its revenue allocation. We have tried to explain the pressures of the European working time directive and of having to maintain consultant staffing in the Western Isles hospital under that, and then having to hit £1 million in 2003-04. The health board was already £0.5 million overspent: it was difficult to pull back from that.

I suppose that we could have done more by being clearer and much harder in saying that we were not going to appoint locum consultants, but that would have meant that we would have had to shut down some clinical services for long periods, which would have been an unacceptable price for the public to pay. While we had to maintain services at broadly the same levels, there was a period between 2003-04 and 2005-06 when we tried to work through new models of care, and we had to accept that we had to bear high costs. That is one of the reasons why we asked the Scottish Executive Health Department for brokerage.

It is fair to say that we did not expect the deficit to be £1.7 million in 2005-06, but during that time, a number of long-standing NHS consultants retired and, because of the difficulty in attracting consultants, we were able to fill those posts only with locum consultants, who were much more expensive than NHS consultants.

David Currie: It was clear to us early on that we faced a difficult challenge. We tried a number of ways of resolving it. We spoke regularly with the then Scottish Executive Health Department and kept it informed about what we were doing and the steps that we were taking. It acknowledged our difficulties and was very supportive of the actions that the board was taking. At no stage did anyone say that they were not happy with what we were doing or that they thought that we had got it wrong. It was very much a case of, "We support what you are doing and hope that it will work out."

The situation was complicated by a number of issues that were building up and by the European working time directive, as Dick Manson said. It was a case of responding year on year to such changes and hoping that we could build up skills and experience and turn the situation round.

George Foulkes: You said that finance was always high on the agenda of your monthly board meetings. At the meeting on 26 May 2005, do you recall an underspend being reported?

David Currie: I do not recall—

George Foulkes: A surplus of £131,000 was reported to the board on 26 May 2005. Do you recall that? You said that finance was high on the agenda.

David Currie: I do not recall that.

George Foulkes: You were chairman of the board, but you do not recall that.

David Currie: No, I do not.

George Foulkes: Does Mr Manson recall it?

Dick Manson: Yes. The underspend was for the financial year 2004-05, if I remember rightly. It had been reported consistently during the year that the board was broadly on target. We started the year with an overspend, but the financial reports to the board and the executive team started to show that the overspend was declining, and then forecast a surplus at the end of the year. However, when the end-of-year accounts were produced, the board discovered that expenditure of about £280,000 or £290,000 had not been reported to the board at any time during the year, or included in any budget statement.

George Foulkes: Is it the case that the draft accounts that were produced before the accounts went to the board showed a £700,000 deficit?

Dick Manson: I do not think so. I have not—

George Foulkes: Did you not meet the board's then director of finance, Marion Fordham? Were not the accounts changed so that instead of reporting a £700,000 deficit they reported a £131,000 surplus?

Dick Manson: I do not recall that at all. As chief executive I would certainly want to question our finance director on the figures, but I would not ask her to change figures that were going to the board.

George Foulkes: Are you saying categorically that if someone published an accusation that you changed the figures you would regard it as wrong and defamatory?

Dick Manson: Yes.

George Foulkes: Can you tell us about the Cook report?

Dick Manson: Sorry—I do not know of a Cook report.

George Foulkes: Are you not aware of an internal report to your management that was called the Cook report?

Dick Manson: I am sorry—I am not.

George Foulkes: Do you remember Keith Craig and Donald Mackenzie, who were in your finance department?

Dick Manson: I do indeed.

George Foulkes: Why did they leave the service of the board?

Dick Manson: Keith Craig retired on the ground of ill health. I think Donald Mackenzie retired.

George Foulkes: You "think" he retired.

Dick Manson: My recollection is that he retired.

George Foulkes: Did either man make a complaint to you about how the accounts were drawn up and presented to the board?

Dick Manson: No.

George Foulkes: Neither of them, ever, on any occasion, did that?

Dick Manson: No.

George Foulkes: So would an allegation that they were forced out of their jobs by you because, in effect, they were whistleblowers about the accounts be entirely false?

Dick Manson: Yes. There is no question of anybody having been forced out of their job.

I think I now understand which report you were referring to.

George Foulkes: Ah! You recall it.

Dick Manson: I have never heard anyone call it the Cook report.

George Foulkes: How would you describe it?

Dick Manson: Significant expenditure was not reported to the board and, in effect, was kept from the board during the year—

George Foulkes: By whom?

Dick Manson: The expenditure was simply not reported. It was kept from the board during the year—

George Foulkes: By you?

Dick Manson: Sorry?

George Foulkes: I do not understand. You, as chief executive, had not reported it to the board.

Dick Manson: No, I as chief executive had not been informed, and neither had the board, of significant expenditure—I think that it was in the region of £280,000 or £290,000—which had been incurred. That had not been included in our financial reporting to me, to my executive colleagues or to the board, and it put us in the position at the end of the year, when the annual accounts were prepared, of suddenly discovering that expenditure was significantly more than we had thought.

I asked Audit Scotland to carry out a review to find out how that could have happened. As a result of its report, I asked Marion Fordham, the new finance director at that point, to consider the report, the changes that needed to be made to internal mechanisms and whether there was a case for any disciplinary action. Marion Fordham reviewed the situation, thought that there might be a case and appointed community services general manager Michael Cook to carry out an internal investigation. I did not see the results of that investigation.

10:45

George Foulkes: You did not see the results.

Dick Manson: No, I did not see the results before I left.

George Foulkes: But there is a report.

Dick Manson: I presume that Michael Cook finished his report—a long time ago now—but I have not seen it.

The Convener: You said that you considered whether there was a need for disciplinary action for the unauthorised expenditure. Did you determine who had authorised it, and what was your conclusion on disciplinary action?

Dick Manson: On a point of detail, the issue was not "unauthorised expenditure" but the non-reporting of expenditure. The expenditure had been kept out of the accounts and from the board.

The Convener: Who was responsible for that, and what was done?

Dick Manson: The ultimate responsibility would be the finance director's. I reported it to our audit committee and the board. We then asked Audit Scotland to carry out a review of what had happened because, as you will imagine, it was a huge concern to us. On the basis of the Audit Scotland report and in accordance with NHS processes, I asked Marion Fordham, as finance director, to review what needed to be done in the finance section to avoid the same thing happening again and to consider whether any disciplinary action was appropriate.

The Convener: But she was the person who was responsible.

Dick Manson: She was not. Marion Fordham had come into post in April, so the previous finance director was responsible. An interim finance director had been seconded for some time from the Scottish Executive to support the board.

The simple questions were: what needs to be done, and should any disciplinary action be necessary? The NHS rules were that it was for Marion Fordham, who was line manager as finance director and who had not been involved, to appoint an appropriate investigating manager at senior level in the organisation. They were to review the facts from Audit Scotland, talk to the internal auditors, get the view of the finance team and then make a recommendation to her.

The Convener: What happened?

Dick Manson: That recommendation had not been made by the time I left.

George Foulkes: I have a couple of other questions on the Cook report. Have you really not seen it?

Dick Manson: I left, so I have not seen it.

George Foulkes: It is reported that the Cook report chronicled dubious accounting practices, profligate expenditure and exorbitant expenses claims. Are you aware of it, Mr Currie?

David Currie: I was aware that that investigation was being undertaken, but like Dick Manson I left before it was finished, so I do not know its outcome.

George Foulkes: What would have happened to the report? To whom would it have gone?

Dick Manson: It would have been presented to Marion Fordham as finance director.

George Foulkes: Would it have gone to the Scottish Executive?

Dick Manson: It would have been for Marion Fordham as finance director to decide whether she discussed it with the Scottish Executive.

George Foulkes: We were told that irregular payments were made to consultants in the Western Isles. Are you aware of that?

Dick Manson: To medical consultants?

George Foulkes: Yes.

Dick Manson: The only regular payments of which I am aware that were made to medical consultants were their salaries and legitimate expenses, in accordance with NHS rules.

When locum consultants came for short terms, there would be negotiations, as there are throughout the country, about whether payments for accommodation and subsistence were appropriate. Those would be decided between the medical director, the human resources team and the locum doctors, depending on how long they came for. If a locum came for three days, he or she would expect accommodation to be provided.

George Foulkes: And no one in the finance department drew your attention to the matter and complained that irregular payments were being made.

Dick Manson: No.

George Foulkes: Ever?

Dick Manson: No.

Andrew Welsh: And there was no machinery for picking that up.

Dick Manson: Irregular payments?

Andrew Welsh: Two hundred and eighty-two thousand pounds is a lot of money.

Dick Manson: Oh—that money. Yes. That should have been in the accounts. There is no doubt about that. That is why we asked Audit Scotland to investigate and report back to us on how the situation could have arisen.

Andrew Welsh: Was there no mechanism for noticing it and picking it up?

Dick Manson: The mechanism would have been that the finance system should have been reconciled back to all the expenditure that was going through the system. It is clear that that was not done.

Willie Coffey: I return to the question that I posed about 10 minutes ago. I want to revisit your statements. I remind you that the information that I have is that, in April 2003, there was no deficit in the Western Isles NHS Board but that by the time you both left the deficit had climbed to £2.5 million. You gave explanations about the European working time directive and so on, but I presume that other health boards in Scotland faced those pressures too. Why did you allow the overspend to take place? Why did you not take action to bring the cost overruns into line?

David Currie: The action that was clearly needed was a service redesign. That was the only way in which we could ensure that the board could live within its means. Service redesign takes a considerable time. We were taking action to bring the board into line, but it was not going to happen overnight. That was an impossibility, given the size of the task.

Dick Manson: It is a matter of public record that, in the financial year 2003-04, the board was facing a £1.2 million deficit. It had submitted a financial recovery plan to the Scottish Executive Health Department and the matter was widely reported in the press in the Western Isles. That is a fact.

Willie Coffey: That was during your term. When you took office, you inherited a zero deficit.

Dick Manson: Revenue expenditure in 2002-03 was subsidised by capital-to-revenue transfers in the region of, I recollect, £0.5 million. It is a moot point whether the board was in balance or not. From where I sit, it was not in revenue balance, because traditionally the board had had to find ways to support its revenue position.

As I explained, the real underlying reason for the board's expenditure continuing to increase and for the board being unable to bring it back into line as quickly as it should have done is that it had to employ locum consultants to maintain clinical services as the working time directive bit. We could simply have ignored the working time directive, but that would have put the board at huge risk of further prosecutions by the Health and Safety Executive. The practice of people being on call 24 hours a day, every day of the year, is not one that guarantees clinical safety for patients. There are only so many hours for which people can work.

The board had traditionally used capital to support its revenue position and it was hit with large increases in expenditure to maintain its clinical services because of the working time directive. It needed to find a way to maintain those services while it developed new models of care. Unlike other health boards, it had limited opportunities to support its revenue position with other one-off contributions. A lot of mainland boards have supported their revenue positions by disposing of property to balance the books.

Western Isles NHS Board was not in that position. It did not have much property to dispose of and land values were fairly low, so any property disposals would have been only of marginal benefit to it. Until the underlying structural issues were tackled successfully, savings could be made at the margins, but not against the main areas of expenditure and cost pressures.

Willie Coffey: Is it true that you appointed three medical directors?

Dick Manson: The answer is probably yes and no.

Willie Coffey: I understand that Greater Glasgow and Clyde NHS Board has only one medical director.

Dick Manson: There was a disconnection between general practitioners and hospital doctors. Traditionally, they had not co-operated well and were finding it difficult to work together. The guidance from the Scottish Executive was that we needed to appoint a board medical director, but there was no agreement among the medical team on that appointment. General practitioners said that they would not support a medical director who was a consultant, and consultants said that they would not support a medical director who was a general practitioner, so there was an impasse. We agreed with them an interim solution, which was to appoint a board medical director whom they all found acceptable. We also agreed to appoint a clinical leader for the hospital and one for community services. The doctors preferred the holders of those posts to be called the community medical director and the hospital medical director. The aim was to improve relationships within two years and to phase out the two posts.

Willie Coffey: It sounds incredible that such a decision was taken because folk could not get on with one another. Surely the paramount consideration in decision making should have been delivery of health services to the people of the Western Isles. The decision must have cost the board a fortune.

Dick Manson: It did not, because the people who were appointed were working doctors who did the jobs part time.

Willie Coffey: They were not doing them for nothing, were they?

Dick Manson: They were not—they received an additional allowance for acting as clinical leaders. We would have needed a clinical leader for the hospital, in any event. The situation seems unusual, and it was not the best basis on which to make decisions, but as chief executive I had to bear in mind that we could not afford to haemorrhage doctors: we could not afford to have consultants or general practitioners leave because of their views and because the board was unable to put in place suitable arrangements. However, a key task was to bring together the two factions and to have them work together on redesigning services. We wanted to get GPs into the hospital to do some of the work so that they could work better for the community. We managed to do that. The medical directors worked as a team to build relationships and to end the difficulties. Our plan was to phase out the three medical directors in 2005-06 and to replace them with one board medical director, because by that time the doctors were willing and able to work together productively.

Stuart McMillan (West of Scotland) (SNP): Were you successful in phasing out the three medical directors by 2005-06?

Dick Manson: They were phased out in 2005-06, but I had left by then. However, I started discussions with them and secured their agreement to the proposal.

Stuart McMillan: Most people accept that operating a health board in the Western Isles

involves higher costs. During our inquiry, we have been told:

"the Western Isles is receiving about 50 per cent more per capita than the Scottish average … and significantly more per capita than Orkney or Shetland."—[*Official Report*, *Audit Committee*, 11 January 2008; c 285.]

The Scottish Executive has confirmed that in the past five years it received no requests for extra funding from Western Isles NHS Board. However, Mr Manson, you have said that you asked the Scottish Executive for extra money and expertise.

Dick Manson: That is right.

Stuart McMillan: But those two statements conflict.

11:00

Dick Manson: They do indeed. It is fair to say that, in October 2003, David Currie and I had that discussion with Trevor Jones—then the chief executive of NHS Scotland—and his colleagues. I had discussions in later years with the finance director and the deputy finance director about NHS Western Isles getting additional money to see it through. The consistent answer was, "No, but we can, perhaps, help with some brokerage, to recognise the fact that it will take more than a year to tackle the underlying issues."

The Convener: Did you ever put anything in writing?

Dick Manson: I do not think that I ever made a formal written request. However, I cannot be sure—we are talking about discussions that took place two or three years ago.

Stuart McMillan: Did you meet those people in Edinburgh?

Dick Manson: Yes.

Stuart McMillan: I assume, therefore, that there are minutes of the meetings.

Dick Manson: I would not have taken minutes, but I will have a scribbled note of the meeting somewhere in my files.

Stuart McMillan: I find it strange that Dr Woods has told us that no requests were ever made.

Dick Manson: Perhaps he is saying that no written requests were made.

Stuart McMillan: I have never been subject to a confidentiality agreement, and I hope that I never will be, but we have been informed that, in recent years, confidentiality agreements have been put in place for some members of staff and people who have left the health board. Would that have had any cost implications?

Dick Manson: I do not think so. I cannot think of whom you are referring to. My sense is that, in any situation in which the board allows people to retire early, confidentiality agreements are fairly standard. We would normally deal with that through our human resources people and our central legal office. I do not see any cost implication in that.

The Convener: Could I clarify that? Are you saying that when senior people in the health board or, indeed, civil servants retire, confidentiality agreements are standard?

Dick Manson: Only in cases of early retirement.

Stuart McMillan: The committee understands that a former member of staff was prepared to provide more information but, due to a confidentiality agreement, they could not do so and the board refused to waive the agreement. Call me naive but, given that we are talking about public money and are dealing with problems that have existed and still exist in the health board, I think that it is incumbent on this committee and every stakeholder to establish the truth about what has happened.

Dick Manson: I agree.

Stuart McMillan: Any confidentiality agreement should be waived in the interests of this inquiry, whether it affects only one person or covers everyone who has a role to play in the inquiry.

The Convener: We could pursue that with the current board rather than today's witnesses.

Stuart McMillan: I accept that, but I would like to ask Mr Manson how many confidentiality agreements were put in place under his tenure.

Dick Manson: I do not have that information, but I do not imagine that it was very many.

The Convener: Presumably, all those who took early retirement were subject to one.

Dick Manson: I think so, yes.

Stuart McMillan: Turning to another issue, I would like you to clarify something for me about internal auditing and internal audit reporting. Do you both feel that there was an inadequacy in the control environment that operated during your tenure?

Dick Manson: Yes. I said in my earlier statement that internal controls needed to be rebuilt. I asked the internal auditors to review the internal control system for me so that, when our new finance director started, we could push forward with a programme to ensure that all the internal controls were in place. We developed and implemented new standing financial instructions, schemes of delegation, decisions referred from the board, reviews of financial controls, limits on purchasing, limits on recruitment and so on to try to get the controls that one would expect in an

NHS board back into the system. I do not think that those measures were fully completed by the time that I left.

David Currie: There were two issues: the processes were not in place for adequate scrutiny and monitoring, and the right skills were not around the board table. It was a case of building those up. As Dick Manson has said, those processes had not been completed by the time we left, but progress had certainly been made.

Jim Hume: This is a question for you, convener, and perhaps for Audit Scotland. Andrew Welsh and I referred to the £1.746 million deficit in 2005-06, which you clarified applied to 2006-07.

The Convener: The budget oversetting was for 2006-07. We received a briefing that indicated that the figure was for 2005-06, but it has been clarified as being for 2006-07.

Jim Hume: So the deficit in 2005-06 was £1.746 million, according to Audit Scotland.

The Convener: Yes.

Murdo Fraser (Mid Scotland and Fife) (Con): Part of the committee's remit in trying to understand the situation around the financial overspend in Western Isles Health Board is to consider leadership and management issues. When we were in Stornoway on 11 January, we took evidence from Malcolm Wright, the former head of the interim support team, who told us:

"There was a breakdown in relations between the board and some of its key staff, which had led to a vote of no confidence."—[*Official Report, Audit Committee*, 11 January 2008; c 234.]

We also heard evidence from a Unison representative about staff concerns over the breakdown in relationships between staff and the board. From your perspective, as leaders in the Western Isles, how would you characterise relationships between the board, senior management and staff? Were there difficulties? If so, what was at the root of those difficulties?

David Currie: Yes, there were certainly difficulties. Relations were very good with some members of the board and with a number of senior staff members, but there were problems with some board members and some staff members. We took a number of initiatives to try to resolve that situation, including staff meetings, away days and development days. Quite a number of different things were tried to move the situation on. However, we were never successful in completely addressing the problem.

Dick Manson: We had a fairly united executive team—remembering that, in the NHS, people have passions about particular issues. We worked hard to achieve board unity, clarity and focus of vision. We set in train a number of ways of engaging with all the staff in the organisation. We had meetings with staff, and the chairman and I went out and about and met staff groups. We worked with some staff groups around particular difficulties, for example with midwives and domestic staff. We met staff regularly in Uist, Barra and Harris, because of their remoteness. We introduced new systems of regular communication.

More than 10 per cent of our staff were involved in our service redesign initiative. Clinical and support staff and members of the public came together to redesign the clinical services. They ran a number of seminars, which I attended, to explain what was happening to all staff.

However, it is clear that we were not successful in engaging everybody. Because of some rumours about potential job losses and about services leaving the islands, our message about having to save money and change clinical services went into a difficult environment. We were not able to engage everybody and we could not properly reassure everybody.

Murdo Fraser: You said that only a minority of staff had concerns. However, you faced a vote of no confidence. What led to that?

Dick Manson: People are always anxious about the future, particularly in the Western Isles, where jobs are not easy to come by. The health board is one of the biggest employers in the Western Isles. Until we started to make changes in late 2005, things had been going pretty well. However, as we started to make changes—tackling issues such as 30 per cent of beds being empty—people got very upset. I think that that led to the vote of no confidence.

Murdo Fraser: We heard earlier that there were issues to do with votes of no confidence when you were at Carstairs. Is this a trend in your management style?

Dick Manson: I do not think so. I was chief executive at Carstairs for 10 and a half years, which is the longest tenure of any chief executive of any special hospital in the United Kingdom. I think that that speaks for itself.

What Carstairs and the Western Isles have in common is that they were divorced from the mainstream of the NHS. For some time, they had been divorced from the need to change, so change was needed to bring the organisations up to date and, in the case of NHS Western Isles, to bring it back into financial balance. The pace of change was rapid, which naturally made some people feel uncomfortable.

Murdo Fraser: From what you are saying, specific issues arose in the Western Isles that would not have occurred had you been dealing with a mainland health board. What sort of issues

arose to do with the recruitment and retention of management during your time in office? Was the turnover of senior staff high? Did specific issues arise when you were trying to recruit the right quality of people to come and work in the Western Isles?

Dick Manson: I do not think that the turnover was high, but a number of senior vacancies arose and it was difficult to recruit people. Working in the Western Isles is not seen as a mainstream, productive career move by NHS managers and senior clinical staff. We therefore asked our colleagues in the Scottish Executive for some support in recruiting people, and we explored with the Executive how we could make NHS Western Isles an attractive stepping stone, where people could perhaps spend two or three years doing certain things before moving out.

We had difficulties when we recruited our finance director. In no way do I wish to demean the quality of the candidate whom we appointed, but we did not have a huge number of applications. We did not attract as wide a field of applicants as one would attract on the mainland. Again, when we tried to recruit a general manager for the Western Isles hospital in order to bring in some expertise in managing hospital-based clinical services, we had a very small short list and found it difficult to recruit. In the Western Isles, it is difficult to recruit and retain people with the right skills.

Murdo Fraser: Were the people whom you were able to recruit of sufficient quality? Was part of the problem in the Western Isles that you were not recruiting the right quality of people?

Dick Manson: That is a difficult question. We managed to recruit some good people, but when I was there I would also have liked to recruit some people with different skills and expertise.

Murdo Fraser: You mentioned a moment ago that you approached the Scottish Executive and NHS Scotland to seek their assistance in recruiting staff. Were they able to help you? Did they provide anything that was of use to you?

11:15

Dick Manson: They were able to help us with an interim finance director—it was somebody from the Scottish Executive Health Department—which was helpful and productive. However, they were not able to help us with the recruitment of other people, such as general managers for the hospital and community and other people in the finance team—qualified accountants, for instance. They were able to suggest NHS boards where we might find people who wanted a secondment opportunity, but they had no magic supply of people who were keen to come to the Western Isles.

David Currie: The issue was very important to us and we raised it with the Health Department on many occasions, because we saw seconding people to the board for the short term or using people to provide mentoring and coaching as one way of plugging the gap. However, we did not get much help with that.

Murdo Fraser: After you stood down, the Minister for Health and Community Care put an interim support team in place. What is your understanding of why that team was put in place?

David Currie: It was interesting that that happened, because that was the kind of help for which we had been looking. It was necessary if the situation was to be resolved. My sense is that it was a political move. If that is the case, it might be that the Executive had a political agenda, although I do not know what it was.

Dick Manson: My sense is that the Executive recognised that Western Isles Health Board had some problems that it had not been able to resolve and that needed wider expertise from people with an independent view.

Claire Baker (Mid Scotland and Fife) (Lab): Mr Currie, you said that it was necessary for the interim team to go in and that the right decision was made. Do you feel that you did not get enough support from the Scottish Executive Health Department prior to that, and that the move should have been made sooner? Could another team have gone in? On what basis would you have liked it to do so?

David Currie: As I said earlier, we asked for that kind of support on many occasions throughout my tenure. It is right that support was put in, but it was important to have the proper remit and agenda. Had support come in when I was there, it would have been important to me for it to have had a proper remit. I am not saying that the interim support team did not have that, because I do not know what its remit was.

Claire Baker: Was your request for support clear enough? Did the Health Department understand what kind of support you were looking for, and was it reluctant to provide it or not in a position to provide it? You talked about the request for financial support, and we have been told that it was not available, but there were also issues with recruitment and management support.

David Currie: The Health Department certainly understood the reasons why we asked for that support. I cannot say why it was unable to provide it, but there is no doubt that it understood the reasons because, in our conversations, officials often acknowledged the difficulties that we had and showed that they understood them.

George Foulkes: Malcolm Wright told us that one of the purposes of the interim support team was to resolve a number of grievances and disciplinary cases. Why did you have such a large number of them, Mr Currie?

David Currie: I am not aware that there was a large number when I departed. When I went into the role, there were quite a number. Mr Manson has already referred to that.

George Foulkes: Yes, but one specific purpose of the interim support team was to resolve the grievances and disciplinary cases, which it did. Why was there such a large number?

David Currie: I am sorry, but I do not recall a large number of such cases. No one ever took out a grievance against me.

George Foulkes: It might not have been against you; it might have been against someone else.

David Currie: I am not aware of any grievance against any member of the senior team.

George Foulkes: Was Malcolm Wright not telling us the truth when he said that various discipline and grievance cases were resolved by the interim support team and that one of its purposes was to resolve such cases?

David Currie: I am sorry, but I cannot speak for Malcolm.

George Foulkes: No, but he has told us that there were grievances and disciplinary cases and you are saying that there were none.

David Currie: I am not aware of any grievances. I think a couple of disciplinary cases may have been under way.

George Foulkes: What about you, Mr Manson? Do you recall?

Dick Manson: I recall them, but there was not a large number of grievances and disciplinary cases. I think one grievance against one member of staff was in progress. As a result of the investigation that I mentioned earlier and of one further investigation, there were potential disciplinary cases and investigations in relation to, I think, three members of staff.

George Foulkes: Why do you think Malcolm Wright was able to resolve them but you could not?

Dick Manson: One reason would be because a lot of the groundwork had been done by the time Malcolm arrived.

George Foulkes: Were the grievances against you?

Dick Manson: They were not.

George Foulkes: None of them?

Dick Manson: None of them.

George Foulkes: One of the other purposes of the interim support team was to establish the community care partnership with Western Isles Council. Why had you not done that?

Dick Manson: We had been working with Western Isles Council for some time to try to—

George Foulkes: But why had you not established a community care partnership with it?

Dick Manson: The reason we had not established it was because we had a proposal for a community health and care partnership that was worked up in partnership with Western Isles Council and approved by Western Isles Health Board. At the last minute, Western Isles Council asked whether we, as a health board, could agree to the powers being delegated not to the community health partnership but to a joint service committee of the health board and the council, because of councillors' anxieties that decisions would be taken in the CHP that they would find difficult.

We took advice from the Scottish Executive on whether what the council proposed was possible, and we were advised that it was not, because Parliament had delegated powers, by statute, to CHPs, so we could not take powers from them.

George Foulkes: Why was it that, in five months, Malcolm Wright and his team were able to establish good partnership working through the setting up of the community care partnership but you were not able to do that in all your time there?

Dick Manson: I cannot speak about that, because I do not know what Malcolm did and I do not know the details of how the CHP was established. We worked hard with Western Isles Council and thought that we shared an enthusiasm and had an agreement with it about getting the CHP up and running. However, at the last minute, we could not meet the council on the one point that, from a political perspective, the council's members felt was important, which was not delegating to the CHP all the powers that Parliament said should be delegated to it. That happened shortly before I left; then Malcolm Wright came in. Perhaps he was able to find a way round that difficulty or to find a better solution.

The Convener: Can I bring in Jim Hume?

George Foulkes: I just want to ask a final question, convener.

There was a vote of no confidence, the deficit had increased dramatically, there were grievances and disciplinary cases, and you could not set up a community care partnership. Did you leave proud of your record?

Dick Manson: I left obviously disappointed that there had been a vote of no confidence. I was also disappointed that Western Isles Council changed the ground rules at the last minute and that we were unable to meet it on that one point. However, given where the health board had come from since my arrival in 2003, the improvements that had been made to financial controls and systems, and the involvement of the staff and members of the public in service redesign, I felt that I left the organisation in a better position and that I had achieved something.

George Foulkes: Have you been back since you left?

Dick Manson: No, I have not.

The Convener: I do not know whether it was fortuitous or just coincidence that a new career opportunity came up for you at that time.

Dick Manson: To be honest, it was perhaps a bit of both. I was looking to move at that point. I am not sure whether it was coincidence.

The Convener: But the job just suddenly came up. It was not advertised.

Dick Manson: I had let it be known to Kevin Woods and to colleagues that I felt that I had done my stint in the Western Isles and that I was now looking for an opportunity to move on to something else.

The Convener: It is fortuitous, to some extent, that they were able to find a post for you somewhere when you wanted to move.

Dick Manson: Yes.

Jim Hume: I return to the discussions and conversations with the NHS. Mr Manson mentioned that he had discussions with the NHS to ask for more funding, and Mr Currie mentioned that there were conversations about getting more staff. As we all know, to get any public money, you have to put up a good business plan. With regard to staff and funds, did you put in a proper request with a full business plan, or did it stay—as you both mentioned—as conversations and discussions?

Dick Manson: It stayed as conversations and discussions. It was very clear that the Health Department could not take money from other health boards and give it to the Western Isles when it needed to tackle areas of inefficiency.

Jim Hume: It is up to every health board to fight its case with all the ammunition that it has. Whether in the business world or in the public sector world, that means putting up a good case.

Dick Manson: It does, but our case for extra money was weak because—as has already been pointed out, and as we knew—Western Isles was funded more generously than any other health board in Scotland. It had made certain decisions about its clinical services that needed to be changed because those services were inefficient—30 per cent of beds were empty at any one time.

Jim Hume: Could you have put in an official request with a written case for funds and staff?

Dick Manson: It was made clear that it was for us to tackle those inefficiencies and that the Scottish Executive would be prepared to discuss brokerage so that extra expenditure or losses incurred in one year could be spread over future years. That was helpful.

On extra staff, we asked the Health Department how it—or the NHS—could support us, as a small board in a remote location, in getting the right skills and expertise into the system to tackle particular issues and then in enabling people to move back into the mainstream NHS. Given that the NHS comprises a number of separate employers, it would be quite difficult for people to do that, because the NHS itself does not employ people—Western Isles Health Board would have had to employ people and then try to retract them. If the question is whether, with the benefit of hindsight, I would have preferred to write all that down and make the case, the answer is yes.

Andrew Welsh: Mr Manson, I am concerned that you seem to dismiss the findings of the interim support team and to consider that you left a reformed and fit-for-purpose organisation. The review pointed out that the board was at risk and that there were doubts as to whether the board got the right information. There was also an issue with the control systems, errors had been made with basic reconciliation of figures and there were serious levels of dysfunction in areas of leadership, governance and management. The endowment committee had not met for four years and committee accounts had not been considered or approved by the board during that period. Patient involvement and public partnership were "not operating effectively". There were weaknesses in control systems and decision making, there were no staff representatives on the board and financial controls were inadequate. That is what the interim support team found. Are you dismissing all of that?

Dick Manson: No, I am not dismissing all of that. On a point of detail, I did not say that I left the health board fit for purpose. I have not dismissed what the team found—I have tried to explain, in response to questions from members of the committee, where I was on those issues and what I did.

On public participation, we established the Western Isles health forum. We set up, for the first

time, an organisation that comprised ordinary members of the public to get them engaged in the health service. We made a start. That work was not as fully developed as one would have expected in the mainstream NHS, but it was an improvement.

You referred to the point that there were no staff representatives on the board. The system in the NHS is that the employee director, who is elected by their peers, is appointed to the board. Appointments to the board are outwith the remit of the chairman or chief executive—they are matters for ministers. If ministers choose not to make such appointments, I, as chief executive, cannot overrule their decision.

11:30

Andrew Welsh: I am concerned. You were the man in charge and were responsible for the good running of the organisation, yet the recovery plan was in a mess, with increasing deficits. On clinical services, we are told that there were disagreements and disarray. Human resources had various other—

Dick Manson: Sorry—what was that about human resources? I missed it.

Andrew Welsh: There were major organisational problems during your watch.

Dick Manson: Absolutely.

Andrew Welsh: So why were they not cured?

Dick Manson: They are not cured. I have tried to explain to the committee that we are talking about long-standing, endemic problems in the Western Isles, which were the result of continual changes in senior management and the lack of normal, national NHS systems. My role was to try to tackle that and to introduce normal, national NHS systems into the organisation. I made some progress in doing that, although I would have liked to make more progress. I am by no means claiming that everything was absolutely perfect when I left. The situation was far from perfect—it was a case of work in progress. It will take more time to put all those things right and to have them operating in the same way as they operate in other NHS boards.

However, the situation needs to be seen in the context that the overriding priority at the time was to get back into financial balance. The board had approved an ambitious financial recovery plan. It had worked up the plan in partnership: it held an away day seminar about it, at which the various budget holders presented their issues and set out how they thought that they could save money—the non-executive directors were engaged in that. The board also set up a non-executive director and an executive director to be responsible for each of the financial savings. There was a detailed, operational financial plan for that. Clearly, that was not all achieved in 2006-07, but some progress was made. On whether the plan was realistic, I would say that it was ambitious, but it needed to be ambitious to take quite large chunks of recurring expenditure out of the system.

Willie Coffey: The financial recovery plan has been described by both Audit Scotland and the interim support team as inadequate, unsustainable and unrealistic. That surely raises questions about your role and involvement in approving the plan. Is not the proof of the pudding the fact that others—including, notably, Audit Scotland—were correct in saying that it was unrealistic, given that the situation worsened from that point on?

Dick Manson: Was the plan ambitious or unrealistic? There is a fine line there. It had been made clear to us that the board had to approve a balanced budget; it could not approve a budget for 2006-07 that did not deliver in-year balance. We therefore had to put together a financial recovery plan that was ambitious—perhaps it was unrealistic.

We asked our internal auditors to review the financial recovery plan that had been put together in the December and January preceding the start of the financial year and to suggest ways of improving its robustness. Clearly, not everything in the plan was delivered; I cannot speak about what was not delivered after I left the health board. We made an ambitious plan and we could do nothing else. However, knowing all the issues in the Western Isles and with the benefit of hindsight, I think that it was probably unrealistic to expect to take that much money out in one year.

Willie Coffey: The information that we have in front of us suggests that the problem was much more than having ambition and being unrealistic. The problem was plainly down to basic errors and a lack of reconciliation within the budget—it just did not add up. It was nothing to do with ambition; it was plain bad accounting, as others have said. What do you say to that?

Dick Manson: That is why our finance director was trying to recruit extra qualified accounting help to the finance team. Within the finance team, there had been long-standing difficulties in getting figures properly reconciled and in doing basic tasks properly. The key task of the new finance director was to rebuild the financial systems and establish financial controls in the board. That is why the finance director restructured the department and was recruiting extra qualified staff with technical accounting skills, using outside consultants to support her in doing that. I understand that she is only now coming to the end of that process because of the difficulty in recruiting people and getting them into the system.

The Convener: Was that weakness in the finance team apparent to you all the time that you were there?

Dick Manson: Yes, it was.

The Convener: How long were you there?

Dick Manson: I was there for three years.

The Convener: Three years, and no progress was made.

Dick Manson: Progress was made.

The Convener: But there was no solution.

Dick Manson: Progress was made, but we could not get sufficient qualified accountants into the finance team for the long term to deal with the problems sooner.

The Convener: Although you could not get an adequate number of suitably qualified people during those three years, did you put in place systems that would give you rigorous financial control?

Dick Manson: Yes—well, we started to rebuild the financial systems, but I do not think that they were complete.

The Convener: Three years seems a long time to take to redesign financial systems.

Dick Manson: It depends on the size of the task. The first stage was conversion to the NHS financial management system. The task in 2004-05 was to introduce that system to NHS Western Isles, where it had not been operating before. The new finance director joined us at the start of 2005-06, and her first task was to ensure that all the financial controls and NHS processes were put in place so that the board got regular, up-to-date management accounts and was reassured that certain things could not happen because the controls were working.

Willie Coffey: Do you accept that the financial recovery plan was undeliverable? You have talked about financial irregularities and a lack of reconciliation. It was not really just about ambition and so on; the plan was just not deliverable in terms of the numbers.

Dick Manson: The lack of reconciliation happened before the last financial recovery plan was introduced. The plan relied on service redesign happening and on some changes in the Western Isles hospital. Given the issues about change in the Western Isles hospital, it was probably overambitious. However, it was certainly worth trying to deliver it.

George Foulkes: You referred earlier to problems being endemic in the Western Isles. Why has John Turner managed to achieve an acceptable financial recovery plan in just over a year when you could not do that in three years?

Dick Manson: It may be that his finance director has now had more time to get into all the issues, and he may have received more support. He is certainly building on the work that I and then Malcolm Wright did. He has that history.

George Foulkes: Why do you think that he is getting more support?

Dick Manson: Because the support team has highlighted how long standing some of the issues are, and the Scottish Executive is perhaps clearer about the need to support the agenda in moving forward.

The Convener: Mr Currie, did the board have a strategy between 2003-04 and 2005-06?

David Currie: Yes. The strategy was about building the governance framework, putting in place all the NHS processes that should have existed, building the skills and experience of both the executive and the non-executive team, and carrying out the service redesign. That was our strategy.

The Convener: Was it a documented strategy?

David Currie: All the various elements will have been documented.

The Convener: As part of that, did you have a financial strategy?

David Currie: Yes, we did.

The Convener: At what point during those three years did you become aware that your financial strategy was failing?

David Currie: Every year was difficult because of various factors that were emerging. I suppose that you are referring to the final year.

The Convener: No. You started in 2003-04 with a strategy, including a financial strategy. At what point did you become aware that the financial strategy was failing?

David Currie: I do not have that detail to hand.

The Convener: From memory, when did it appear to you that there was a problem and that your financial strategy was not capable of dealing with it?

David Currie: In, I suppose, 2005-06—there were clearly problems during that year.

The Convener: Were no alarm bells ringing in the previous two years?

David Currie: There were no alarm bells as regards being unrealistic in relation to achievement of budget; there were just unforeseen problems emerging that had to be factored in.

The Convener: Were there no alarm bells about inappropriate spending or deficit?

David Currie: We had taken action to resolve any issues that emerged on inappropriate spending. Any issues that came out during that time were actioned. What was the second point?

The Convener: Were there no alarm bells about deficits?

David Currie: If we thought that we were heading for deficits, there would be alarm bells.

The Convener: So was an alarm bell ringing in 2003-04?

David Currie: Yes.

The Convener: And was an alarm bell ringing in 2004-05?

David Currie: Yes—in both, and we took action to resolve the problems.

The Convener: Did the action taken improve matters, or did matters get worse?

David Currie: It improved matters in some cases. It might not have given us the answer that we ultimately wanted, but progress was made, although perhaps the problems were still building in other respects.

The Convener: Okay. What performance management information did you provide to your board, and how regularly was it provided?

David Currie: There were finance reports to the board every month—that will be documented.

The Convener: What about information on other matters?

David Currie: We built the governance structure around the clinical governance, staff governance and remuneration committees, and they reported to the board as well.

The Convener: On a monthly basis?

David Currie: No, not necessarily—it depended on the nature of the committee. Some did not report nearly so frequently.

Dick Manson: We set out for the board in 2005 a clear programme of performance review. At each board meeting, the board would hear about and review progress against each of its key deliverables for the Scottish Executive and its key deliverables on finance. It would also review a forward plan for building up the planning process, starting with the director of public health's annual report, which should be a health state-of-the-nation report. We built on service redesign and, from that, financial planning. We set that out, and we reported to the board regularly.

11:45

The Convener: But that was just towards the end of your tenure.

Dick Manson: I think that we set out the programme in 2004-05 and started the reports from September or October 2004.

The Convener: But there was nothing prior to that, even though problems were mounting.

Dick Manson: Prior to that, the board considered the financial report at every meeting. We increased the frequency of board meetings, which had been bi-monthly, from six to nine per year, so that we could consider reports more regularly. Prior to that, our consideration of other key targets such as waiting times targets had been more haphazard and less regular than we would have liked it to be, which is why we stepped it up.

The Convener: Mr Currie, were you happy with the board's performance from 2003?

David Currie: There was a lot to do and we had a big agenda. I think that we gave it our best shot. The work was not complete by the time that we left, but I think that the board was improving year on year in its cohesion, understanding and capability. However, problems were increasing at a considerable rate. I was happy that we were making progress—as was the Scottish Executive Health Department, which told us each year that it was happy with the progress that we were making—but I knew that there was a long way to go.

The Convener: Were you satisfied with the quality of information that the management was providing to you?

David Currie: Not initially, but that was work in progress. The quality of information was constantly improving, but there were significant problems earlier.

The Convener: When?

David Currie: There were real problems when I went into post in 2001 and for a couple of years after that.

The Convener: So by 2003-04—

David Currie: We were beginning to make progress. Quality was improving. It was a case of building processes and the governance structure and getting the information on the back of that.

The Convener: However, despite the improvements in quality, the deficits seemed to increase.

David Currie: Yes. There are a number of reasons for that, which we have gone into. A number of problems were building up, which had to be addressed.

George Foulkes: You said that the Scottish Executive Health Department was satisfied with things in NHS Western Isles. Is that right?

David Currie: Yes. At the annual—

George Foulkes: Is that the impression that you got throughout your tenure?

David Currie: Yes. At each annual accountability review the department acknowledged that there were problems but said that it was happy with the way in which we were tackling them. At no time did anyone say that they were not happy.

George Foulkes: Let us consider the chain of command. To whom in the Health Department did you report on a day-to-day basis?

David Currie: There was no day-to-day reporting—

George Foulkes: Week to week, then.

David Currie: I reported to Kevin Woods and to the minister.

George Foulkes: To whom did you report before Kevin Woods was in post?

David Currie: Trevor Jones.

George Foulkes: Did anyone under Kevin Woods and Trevor Jones keep a particular eye on the Western Isles?

David Currie: Yes, at various times. At one stage Alistair Brown was the contact. Geoff Pearson also handled Western Isles issues for some time.

George Foulkes: And at all times did Alistair Brown, Geoff Pearson, Kevin Woods and Trevor Jones say that they were happy with what was happening in the Western Isles?

David Currie: No; they said that there were a number of issues, but they were happy with the way in which we were tackling them. That is the point that I was making.

The Convener: You said that you reported to ministers. Were they equally happy?

David Currie: We reported to ministers at the annual accountability review.

The Convener: Were ministers satisfied, if not with performance, then with the way in which you were handling the situation?

David Currie: Yes, they absolutely were. They had concerns about financial balance and other issues but were happy with how we were tackling those issues.

The Convener: Is there truth in the rumour that ministers wanted to sack the board and the management?

David Currie: I have not heard the rumour.

George Foulkes: Would it be incorrect to suggest that Andy Kerr stepped in and asked you and Mr Manson to go?

David Currie: Yes, that would be incorrect.

George Foulkes: So, as chairman, the decision to leave was completely your own, for your own reasons.

David Currie: Yes. I have explained the reasons why I left when I did.

George Foulkes: Mr Manson, you left completely of your own volition, without any suggestion from the Executive that you should go.

Dick Manson: Yes.

Jim Hume: Donald Macleod was director of finance from 1995 until November 2004. Obviously, 2003-04 was when the deficits started to mount up. He was then appointed internal audit and risk manager. Is it not rather strange that someone who is finance director, who put you into a deficit position—or who started the deficit position—should then be put into audit and risk management? Whose decision was that?

Dick Manson: It was his decision and that of the board.

Jim Hume: He decided to become the audit and risk manager. Surely he had to apply for the job.

Dick Manson: I am trying to remember the sequence of events. He was our finance director. In discussions about rebuilding the governance arrangements and, in particular, the risk management agenda, he expressed an interest in taking forward that agenda for the board. He had always been interested in audit—he was originally an auditor—and he was also interested in the risk management agenda. He expressed the view that he would like to take up that agenda on behalf of the board. However, he recognised that, being the finance director, there was a conflict of interests—he could not do both. He thought about what he wanted to do and expressed a preference for the other job. That fitted well with what the board needed to do because it did not have expertise in that area. It also fitted well with enabling a review of the finance function.

Jim Hume: Did that leave a gap? You say that it is difficult to get good staff. He was someone with nine years' experience who, to my simple mind, took a demotion.

Dick Manson: I did not see it as a demotion, and nor did the board. I do not think that there was any question of our even thinking about demoting him.

Jim Hume: He was not asked to leave because he had made a deficit of £0.5 million as a financial director—

Dick Manson: He certainly was not asked to leave for that—he was not asked to leave at all. On the financial deficit, he was reporting on the figures throughout the year. He was warning the board throughout the year about the impact of the high cost of locums. That was a question about whether we should stop clinical services. When he left, that left a bit of a gap because of the need to recruit a new finance director, although it was an opportunity to have a review of the finance function. The Scottish Executive agreed to second in an interim finance director from the Health Department. Mr Macleod agreed to stay on as the finance director until then, to have a handover and to be available to support that person if needed. We were able to manage that.

Jim Hume: He willingly gave up his job as a financial director because he wanted to become a manager.

Dick Manson: Yes. He gave it up because he wanted to take on risk management and audit.

The Convener: Finally, Stuart McMillan has a question on confidentiality agreements.

Stuart McMillan: In your experience, is it normal for members of staff who still work for a health board to sign confidentiality agreements?

Dick Manson: It is not routine. My experience is that it is normal when people are retiring early on the grounds of organisational change or in the interests of the efficiency of the service.

The Convener: Thank you. It has been a long and wide-ranging session. Do either of you have anything to say in conclusion, or do you feel that you have covered the ground adequately?

Dick Manson: I have nothing else to add.

David Currie: I think we have covered the ground.

The Convener: Thank you again. We will deliberate and will report in due course.

11:54

Meeting suspended.

12:01

On resuming—

Scottish Futures Trust

The Convener: Agenda item 3 is consideration of a paper from the Auditor General for Scotland on the proposal to establish a Scottish futures trust. I invite the Auditor General to speak to his paper.

Mr Robert Black (Auditor General for Scotland): Thank you very much, convener. Russell Frith, who is director of audit strategy for Audit Scotland, is with us. He is our technical expert on auditing matters.

The Government is consulting on the possibility of establishing a Scottish futures trust that would drive infrastructure investment at some point in the future. I thought that it would be useful to provide members with an information paper on the proposal, which is very much an outline proposal at the moment. I emphasise that I am well aware that the Finance Committee is in the early stages of its inquiry into the funding of capital investment projects, which is an entirely appropriate matter for it to deal with, but if the Scottish futures trust proposal progresses, issues to do with its governance, accounting and auditing arrangements that could be significant in the longer term will arise. The proposed trust could play an important role in the procurement and delivery of capital projects, so I thought it right and proper that members should be aware of such a developing issue. Once the proposal is more fully developed, it may be necessary for us to come back to the committee with a further paper.

Russell Frith is willing to give a brief outline of what is involved and our general sense of what the high-level governance, accounting and auditing implications are, if the committee would find that helpful.

The Convener: We would.

Russell Frith (Audit Scotland): Thank you, convener.

As the Auditor General said, the Government's consultation paper was designed to seek views at an early stage in developing what is seen as an alternative to private finance initiatives or public-private partnerships for channelling public and private capital into infrastructure investment projects in Scotland. The Government has recognised that several challenges are faced in proposing any alternatives to PFIs, some of which could affect current PFI proposals and arrangements.

For example, members may be aware that next year the United Kingdom Government will

introduce international financial reporting standards. One likely impact of that change is that a number of PFI projects that are currently off the public sector balance sheet and do not count towards Government borrowing will have to come on to the balance sheet and so will count towards total Government borrowing. That poses a risk to the ability of current PFI projects to increase the amount of available investment in public projects, which will carry across to the Scottish futures trust. One possible way of dealing with that would be to place the trust in the private sector in some way. Of course, that raises governance and accountability issues that will need to be addressed as the proposal is developed.

The structure of the trust is another issue that will need to be addressed. At the moment, there are very outline proposals for how the trust will be structured. One model that may inform further development is that of Welsh Water, which has a public interest board comprising about 50 members of the public.

The other key objective of the trust is to change the finance costs of future capital projects—in particular, to reduce overall finance costs and to eliminate or reduce the returns that some equity participants in existing projects are making. Further risks are associated with that objective and will need to be addressed during the development phase. For example, if equity returns are not available, it is possible that fewer contractors will be willing to compete for such projects. However, only when a firm model has been developed will it be able to be tested.

I have given a brief outline of the proposal and of some of the issues associated with it. I am happy to try to answer the committee's questions, bearing in mind the fact that the trust is at a very early stage of development.

Mr Black: We will make a short submission to the Finance Committee. It will say that robust governance arrangements must be put in place, especially if we are to have a vehicle that is slightly distanced from Government. We will invite the Finance Committee to bear in mind the need to consult us on the accounting and auditing implications of the proposal further down the road. It is appropriate that the Audit Committee should be aware of that.

Murdo Fraser: I have a couple of questions about what we have just heard; I am not sure whether Mr Black or Mr Frith should reply. I am interested in where the Scottish futures trust will sit in relation to the public and private sectors. Mr Frith, you suggested that there are clear advantages in placing it in the private sector, although that would have various implications for governance and reporting. Is that a fair summary of your point?

Russell Frith: Yes.

Murdo Fraser: You mentioned the Glas Cymru model that is used for Welsh Water. Is that a good fit for the Scottish futures trust, given how it is intended to operate?

Russell Frith: I am not sufficiently involved in the detail of the trust's development to say whether the Glas Cymru model could be carried across precisely. However, it is one public participation model that is up and running in the UK.

Murdo Fraser: In your view, would the model work for the Scottish futures trust, given the policy direction that has been set for the trust?

Russell Frith: I do not know enough about the detail of it to be able to answer the question.

Murdo Fraser: Is there some irony in the fact that the Welsh Water model is deemed to be good enough for schools and hospitals but not good enough for the water industry in Scotland?

Russell Frith: I do not think that the Government has yet formed the view that the Welsh Water model will form the model for the futures trust.

Murdo Fraser: I appreciate that. It was an entirely unfair question to ask someone who is not a politician. However, you will be aware that we have had some lively debate during the past week about the Scottish water industry and it is interesting that, although the Welsh Water model does not appear be on the agenda at the moment, it might be suitable for the futures trust; that was the point that I was trying to make. Thank you for answering my questions.

Willie Coffey: Will the adoption of the new international regulations have an impact on existing PFI schemes, notwithstanding the impact that it might have on the futures trust?

Russell Frith: The Financial Reporting Advisory Board, which advises the Treasury on the precise accounting policies to be adopted, meets tomorrow to consider PFI accounting under international standards. If the proposal in the Treasury paper is adopted, the answer is yes, the way in which existing projects are accounted for will change and they will come on to the balance sheet.

The Convener: Will that impact on all the Scottish projects as well?

Russell Frith: Yes, it will.

Claire Baker: I have a couple of questions on timescales. The proposals are still at the outline stage and there is still a development process to go through. There are issues around the funding that is available for infrastructure projects,

particularly schools. Can any indication be given of when we could expect the Scottish futures trust to start releasing money for such projects?

Mr Black: We are not really in a position to answer that. It is a Government issue.

The Convener: That is really a question for politicians.

Claire Baker: Perhaps I could ask a linked question to which Audit Scotland might be able to respond. As a comparison, how long did it take for PFI to become a workable model? That might give me an idea of the timescale.

Russell Frith: It is quite a long time ago. Negotiation of the early projects probably took two to three years, but the model changed as people learned from the experience of the first few projects.

Claire Baker: That is helpful.

George Foulkes: Paragraph 9.2 of the consultation paper states:

> "SFT will be run on non-profit distributing principles and would obtain its funding through bonds and other appropriate commercial financial instruments at rates which would be cheaper than those involved in PFI procurements."

I am interested in getting cheaper rates. What are the bonds and "commercial financial instruments"? How can I identify them?

Russell Frith: Bonds are slightly more complex, in that for them to work effectively means relying on tax changes that are in the gift of Westminster. The underlying idea is that if we package together a number of individual projects and put a single, larger package of financing out to the market, we ought to be able to obtain some economies of scale in the interest rate obtained and, perhaps particularly, in the fees involved in negotiating the deals.

George Foulkes: They could be packaged together for a PFI project, could they not? We could achieve economies of scale by having all PFI projects financed by a single institution.

Russell Frith: That might be possible. I am not aware that it has been tried so far.

George Foulkes: It just seems to me to be like making wine out of water if we are able to get cheaper financial rates just because something is called the Scottish futures trust. If it can be done, why has no one else thought of it?

Mr Black: If I may say so, convener, I acknowledge that that is a reasonable question to put to us, but it is very close to policy, and therefore an appropriate issue for the Finance Committee to pursue, as I am sure it will.

The Convener: I suspect that that is something that the Finance Committee will consider. The point that you made earlier was that the proposal will have significant implications for auditing practice and procedures. We will need to consider how we engage properly with the process at that point, while the Finance Committee looks at the broader policy implications.

12:15

George Foulkes: Would it be proper for the Auditor General to consider what the costs of administering a Scottish futures trust might be?

Mr Black: If the Scottish futures trust were to come to fruition, once it was in operation, the governance arrangements could be subject to audit, depending on the policy framework in which the trust was sitting.

Before the committee moves on, I should clarify a point that I made earlier, in case I misled the committee slightly. It has been pointed out to me that I should say that our submission will be going to the Scottish Government not to the Finance Committee, as part of the consultation process that is under way.

The Convener: Thanks for that clarification. We await with interest the eventual outcome.

Audit Scotland (Work Programme)

12:16

The Convener: The next item on our agenda deals with Audit Scotland's work programme.

Mr Black: I thought it appropriate to draw to the committee's attention my response to a request from the Scottish Government for me to carry out a review of expenditure on and the effectiveness of drug misuse services in Scotland. I would welcome any views or suggestions that the committee has on the matter.

When we have consulted on our forward work programme in the past, the suggestion has been made that Audit Scotland might well consider expenditure on drug misuse services across the board. Given the importance of the area to the Parliament and communities across Scotland, and also given my sense that Audit Scotland could make a distinctive contribution in this area, I have agreed to include the study in the work programme.

From time to time, we have commented on drug-related problems. In the most recent overview of the NHS, which the Audit Committee considered not that long ago, we highlighted the significant growth in drug-related deaths and the prevalence of drug problems among the younger age groups in deprived areas. The issue is recognised as a significant one.

We will attempt to conduct a review of expenditure on drug services. We will consider the role of partnerships in addressing drug-related problems in their areas and the contribution of the relevant public sector bodies. We will do that across the whole of the public sector—from the NHS through to local government—because we are uniquely well placed to do that.

We are consulting a wide range of stakeholders and would welcome any views or suggestions from the committee about the review, either now or at a later date. Barbara Hurst and Angela Canning are involved in scoping the review and can help you with any questions.

The Convener: As no one seems to have any questions at the moment, we will note what you have said about the work programme and return to the matter when the report is published.

At this stage, we move into private session.

12:18

Meeting continued in private until 12:40.

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