AUDIT COMMITTEE

Tuesday 23 January 2001
(*Afternoon*)

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AUDIT COMMITTEE
2nd Meeting 2001, Session 1

CONVENER

*Mr Andrew Welsh (Angus) (SNP)

DEPUTY CONVENER

*Nick Johnston (Mid Scotland and Fife) (Con)

COMMITTEE MEMBERS

*Scott Barrie (Dunfermline West) (Lab)
*Margaret Jamieson (Kilmarnock and Loudoun) (Lab)
*Paul Martin (Glasgow Springburn) (Lab)
*Mr Lloyd Quinan (West of Scotland) (SNP)
*Mr Keith Raffan (Mid Scotland and Fife) (LD)

*attended

WITNESSES

Mr John Aldridge (Scottish Executive Health Department)
Mr Eric Harper Gow (Common Services Agency)
Mr Trevor Jones (Scottish Executive Health Department/Chief Executive of the National Health Service in Scotland)

CLERK TO THE COMMITTEE

Callum Thomson

SENIOR ASSISTANT CLERK

Anne Peat

ASSISTANT CLERK

Seán Wixted

LOCATION

The Chamber

Scottish Parliament

Audit Committee

Tuesday 23 January 2001

(*Afternoon*)

[THE CONVENER *opened the meeting at 14:01*]

The Convener (Mr Andrew Welsh): I welcome members and Audit Scotland officials to this meeting of the Audit Committee. I remind everybody that all mobile phones and pagers should be switched off. The clerk has indicated that no apologies have been notified.

Item 1 is committee business. I seek members' approval to take agenda items 2, 4 and 5 in private, as they are internal, housekeeping matters. Do we agree to take those items in private?

Members *indicated agreement.*

14:02

Meeting continued in private.

14:09

Meeting continued in public.

National Health Service in Scotland 1999-2000

The Convener: I welcome the witnesses to the meeting. Today we are examining financial stewardship in the national health service in Scotland, based on the Auditor General's 1999-2000 overview report. I understand that the facts in the report have already been agreed.

We shall be asking our witnesses questions on three main areas: first, the financial performance of NHS trusts, including the purpose of financial targets and the reporting of overall financial performance in the NHS in Scotland; secondly, the new system for primary care payments, including the availability of management information and the arrangements for the verification of payments after they have been made; and, lastly, the implications for the NHS in Scotland of the implementation of European Union working time regulations.

In line with our normal courtesy, I invite Trevor Jones to make an opening statement if he so wishes. I believe that Mr Harper Gow has said that he does not intend to make a statement, but I will extend the opportunity to Mr Jones.

Mr Trevor Jones (Scottish Executive Health Department/Chief Executive of the National Health Service in Scotland): I welcome the Auditor General's report, which is very useful to the health service. I also wish to put on record my recognition of the good working relationships between the service and Audit Scotland, which make for a constructive process.

To set the report in some perspective, 1999-2000 was not a typical year for the national health service. First, there had been a major structural change, with a reduction in the number of trusts. Secondly, there was a major change in our handling of primary care payments in that year. Thirdly, that financial year contained 31 December 1999 and the fears of the year 2000 problem.

Bearing that in mind, I was pleased that the Auditor General's report recognised the high standard of financial stewardship in the national health service, recorded that governance in the service is sound and said that the standard of internal audit is high. It was good to note that no NHS organisation's accounts were qualified by the auditor during the year and that overall NHS expenditure was within 0.5 per cent of the break-even target in the year.

Against that context, we still need to discuss some important issues. We are certainly not

complacent and we welcome the discussion that we are about to have.

The Convener: This is the first overview report on the NHS in Scotland—that is, of course, a major area of expenditure, for which you are now responsible. In light of what you have said, I agree that 1999-2000 was not a typical year, but how satisfied are you with the overall performance in the NHS in that year?

Mr Jones: Overall, I am satisfied with the performance. That does not mean that no issues need to be addressed—indeed, the report highlights a range of issues. For an organisation managing a budget of about £5 billion to have achieved financial balance to within 0.5 per cent is quite a good outturn. I reiterate that there are issues that we need to address—we will take those very seriously.

The Convener: Do you consider that, in general, NHS trusts face real challenges in meeting their health care commitments as well as in meeting the financial targets that you set for them?

Mr Jones: Indeed they do. The whole of the NHS faces real challenges. As you can imagine, the potential demand for service and the degree of innovation in the service always produce development pressures. With the implementation of "Our National Health: A plan for action, a plan for change", we are proposing to review the finance regime in the NHS and to improve our management of the pressures in heath board areas. We might move on to discuss that later.

The Convener: Current account deficits surely cannot co-exist with service improvements. How long do you estimate that the deficit will last? Is there light at the end of the tunnel?

Mr Jones: I think that there is light at the end of the tunnel. Under the new finance regime, we will be managing NHS organisations in an area as a single entity, bringing together different parts of the organisation, which could include one trust that was overspending in an area and another trust that was underspending in the same area by an equivalent amount. We will be changing the governance arrangements to arrive at a much more sensible, integrated approach to the financial position of the various organisations within a health board area. The new finance regime will allow us to advance significantly.

The Convener: I invite Paul Martin to start the questions on why NHS trusts are experiencing difficulties in achieving their financial targets.

14:15

Paul Martin (Glasgow Springburn) (Lab): Mr Jones, I refer you to paragraphs 3.5 and 3.6 of the Auditor General's report, which highlight the fact that eight trusts have failed to break even. When did your department become aware of difficulties with deficits? Furthermore, what action was taken locally to address the issue?

Mr Jones: I will ask John Aldridge to answer that question, as he was working in the department at the time.

Mr John Aldridge (Scottish Executive Health Department): Throughout the year, we regularly monitor the financial position of the NHS trusts across Scotland. We ask them to forecast their performance through the year to find out how they will meet their financial targets in that year. However, it becomes clear only at different points of the year whether the various trusts are facing difficulties that might cause them to move into deficit. As soon as we become aware of such a situation, my colleagues and I contact the trust to identify the problems and to determine whether they can be resolved straightforwardly. If they can be, that is fine. However, if the problem is more deep-seated, we will ask the trust to prepare a recovery plan to demonstrate how it can move back into balance over whatever period of time it takes. We will obviously try to ensure that that period is as short as possible, although sometimes that is not practical because of the nature of the problems.

Paul Martin: I am sorry if I have not picked up the point, but when exactly did you intervene in the process?

Mr Aldridge: Well, we intervene in a progressive way.

Paul Martin: When exactly did you intervene?

Mr Aldridge: I am sorry. Are you talking about a particular trust or trusts in general?

Paul Martin: Well, you can refer to a particular trust if you want to. More generally, for the eight trusts with deficits, when exactly did you intervene in the process? Did you do so when you became aware of the problem?

Mr Aldridge: We intervene when we become aware that there is a possibility of a trust moving into deficit, which can happen at any time in the year. If the trust reports to us that it is moving in such a direction, we immediately make contact and discuss the seriousness of the problem and the actions that need to be taken. There is no specific date on which we become aware of the position of the trusts; it varies from trust to trust.

Paul Martin: I am sorry to labour this point, but do you have the information about when your organisation became aware that the eight trusts were going into deficit?

Mr Aldridge: Certainly. We receive regular

monitoring reports from the trusts, which show when they are heading for deficit.

The Convener: How regular are those reports and what form do they take?

Mr Aldridge: The process speeds up over the year. We receive three-monthly reports in the early part of the financial year and monthly reports as the year draws on.

Paul Martin: Paragraph 3.9 of the Auditor General's report indicates some of the main reasons for the deficits, such as

"Costs associated with covering staff vacancies by overtime and bank and agency nurses".

Do you agree that the reasons set out in the report resulted in the deficits? Are there any other factors that you would like to add to that list?

Mr Aldridge: All the factors set out in exhibit 5 of the report certainly cause trusts to have financial pressures at various times in the year; indeed, in some cases, those factors might cause them to move into deficit. However, not all the issues will affect every trust.

Paul Martin: But do you agree with the factors listed in paragraph 3.9?

Mr Jones: The list gives good examples of the range of the issues that must be addressed within the NHS.

Paul Martin: Are there any other factors that you would like to add as part of your evidence today?

Mr Jones: No.

Mr Keith Raffan (Mid Scotland and Fife) (LD): We have talked about seeing the light at the end of the tunnel and getting the trusts back into the black as soon as possible. Paragraph 3.15 outlines major problems for the future, such as demography and the aging population, technological and pharmaceutical change, and rising expectations.

I do not see how one can consider the issue of new drugs coming on to the market in straight financial terms without thinking about serious rationing in the health service. Let me give two examples. First, the new drug Trizivir, for the treatment of HIV/AIDS, costs just under £700 per patient per month. How do you cope with that? That might not be a particularly good example in numerical terms in Scotland, but perhaps my second example is more significant. Last Thursday, the Parliament had a debate on hepatitis C. It is reckoned that there are 40,000 cases in Scotland and a course of interferon alpha and ribavirin costs £5,000 to £10,000 per patient. We are talking about huge sums of money. How on earth can we expect trusts to get back on track financially unless they decide not to fund new services?

Mr Jones: Three points can be taken into account. First, the allocations to health boards and from the boards to the trusts are not fixed; they increase each year. Significant additional resources are going into the NHS over the next three years. That is a rate of increase over and above the estimated rate of inflation. Additional resources are available to cope with some of the issues that you raise. Secondly, it would be wrong to assume that the NHS is currently working at its ultimate efficiency level. Things could be done differently in NHS systems to improve services and to reduce costs.

Thirdly, as the Auditor General's report recommended, we should reconsider the financial regime in the NHS. We must think about trust targets and the way in which we control resources in the NHS. We want to move to a situation where we are thinking about the overall financial position of a health board area, rather than simply the financial position of, for example, an acute hospitals trust. The report shows that overspending tends to take place in acute hospital services. If members consider the trusts that are not listed as overspending, they will find that in some health board areas acute hospitals are overspending when primary care trusts are in surplus. There are issues about how we manage the total health system in an area in order to achieve a better result for the population and patients of that area.

Mr Raffan: I have talked to representatives of the three health boards in the region that I represent—Tayside Health Board, Fife Health Board and Forth Valley Health Board—and they say that they have made efficiency savings and have been cut to the bone. They say that they will now have to move from cutting administration and bureaucratic costs to rationing health care—they will have no option if such savings are imposed on them. You are talking as part of the Executive, Mr Jones, from your headquarters here in Edinburgh, but those in the front line have a different view. They are all saying the same thing. Perhaps they are colluding, but they are saying that they are being asked to make efficiency savings over and again and that they have been cut to the bone.

Mr Jones: First, let me repeat the point that all health boards are being funded in excess of the rate of inflation. Secondly, I am not simply speaking from the Scottish Executive viewpoint. I have recently joined the Scottish Executive, having been chief executive of a health board in Scotland. Before that I was chief executive of an NHS trust in England.

It is easy to say that every organisation—whether in the public or private sector—is

operating at the peak of its efficiency. I do not think that that is true of the NHS. I am not saying that there is significant inefficiency in the service, but I do not think that any organisation can say that it cannot get better. That becomes more difficult year on year, but it would not be right for anyone to say that things could not be better organised.

Mr Raffan: I understand that the trusts have to get the boards' agreement on new services, yet in 1999 or 2000 some trusts made changes before agreements had been reached. There appears to be little or no control in those examples.

The Convener: Before Mr Jones answers that, I must point out that you are in danger of straying into areas that are covered by other questions. I would like us to stick to—

Mr Raffan: Sorry, I will stick to the question that I asked, which is question 3.

Mr Jones: In the NHS, one of the most difficult areas to control is clinical development, particularly in hospitals that are associated with a medical school. World leaders in clinical excellence are seeing new and different ways in which to provide services. At times, that development is incremental and can creep into the system. That is difficult to control, but you are right in saying that we must get better in that area. It is always difficult to manage an organisation financially if one is placed on the back foot trying to cover the costs of developments. We need to improve the ways in which new developments are introduced into the NHS.

Mr Raffan: How will you do that?

Mr Jones: By having stronger relationships between those who are instigating the innovation—the leading doctors—and the trust that manages the hospital. It is critical that the right relationship between medical staff and the managers of organisations is developed. I know that my colleagues in trusts are working actively towards that.

Mr Raffan: How do you ensure that recovery plans are sound?

Mr Jones: I will ask John Aldridge to answer that.

Mr Aldridge: When we receive a draft recovery plan, we discuss it carefully with the trust and with the health board to ensure that the NHS in the area is satisfied that the proposals in the plan are not only realistic but can be delivered practically without adversely affecting patient care. That is why financial recovery can take longer than it might otherwise. We monitor the plan's performance monthly to ensure that it is delivering on the milestones that are set out. If the plan states that, by the end of a certain month, a set amount of savings or a specified set of changes to the way in which services are delivered should have been made, we check that that has happened. If the plan goes off track, we ask for a revision.

Mr Raffan: I do not want to get bogged down in the issue of Tayside, but it is an example of a recovery plan going off track. In year 1, the plan was on course to deliver the necessary savings but, in year 2, the deficit was up to £10 million because of the junior doctors working directive. Such things can crop up and they must be difficult for you to deal with.

Mr Aldridge: Matters arise that can affect the recovery plan, which is why it needs to be kept under review.

Mr Raffan: How can the plan be put back on course?

Mr Aldridge: Other options can be considered. Further changes can be made to the way in which services are delivered, or the time allocated for achieving balance can be lengthened. The solution will depend on what is reasonable in the circumstances. In the case of Tayside, although not all the items that were originally intended to contribute to the recovery plan have been achieved, the overall financial position for this financial year appears to be turning out as planned.

The Convener: I should point out that the committee will be examining the Tayside situation at a later point.

Mr Jones: It would be naive if in formulating recovery plans, health organisations did not take into account the fact that, every year, there are additional pressures and new developments that must be coped with. I would expect recovery plans to include contingency plans for such situations. We may not be able to forecast precisely what the issues will be, but the history of the NHS shows that there are always additional pressures, year on year, which must be taken into account in the formulation of a recovery plan—otherwise, the trusts will never get out of deficit.

The Convener: You may agree changes that are necessary for a trust to get rid of a deficit, but what is the role of the general public?

14:30

Mr Jones: As we are formulating long-term plans for the NHS, which include financial plans, we should engage the public in addressing some of the issues. It is critical to establish a relationship with the general public. I know from experience that they understand that any service—whether the NHS or any other service—must live within the resources that are available to it and that difficult

decisions occasionally have to be made.

An issue that has been picked up in the health plan is that it is important for the NHS to establish a sensible dialogue with the general public on the reality of the situation and to explain some of the choices that are available in the management of its resources. It is important that we engage key stakeholders when we make decisions to ensure that the NHS moves forward in a managed and sensible way.

The Convener: Those are not simply technical, internal matters.

Mr Jones: No.

Paul Martin: The financial pressures of 1999-2000 have continued into the current financial year, as paragraph 3.16 of the Auditor General's report points out. How many of the 28 trusts expect to achieve the break-even target at the end of the current financial year?

Mr Jones: I do not have that information in front of me, but I can provide it to the committee.

Let me put the situation into context. In my introductory comments, I said that the deficit was within 0.5 per cent of the target for the NHS in Scotland in 1999-2000. The highest deficits for the health board areas are Tayside at 2.4 per cent and greater Glasgow at 1.7 per cent. However, three of the health board areas that contain the trusts listed in exhibit 4 in paragraph 3.6 were running at deficits of below 0.4 per cent. Therefore, the health board systems are not running significant deficits in percentage terms. In cash terms, the deficits appear significant, because the budgets are very large, but in terms of the overall management of the organisations, those sums can be managed and contained.

At the moment, we do not have the requirement to manage the total resource in a health board area to get the best result for the whole population. That will come in the new finance regime and is one of the recommendations in the Auditor General's report.

Paul Martin: So you are effectively presiding over £30 million of deficit in respect of the 28 trusts.

Mr Jones: No—

Paul Martin: Let us forget about percentage terms. Let us be clear.

Mr Jones: Factually, what you suggest is not the position. Trusts in deficit had a total deficit of £29 million, but some trusts among the 28 were in surplus to the tune of around £10 million. The net deficit of trusts was less than £20 million; it was not £29 million.

Paul Martin: The Auditor General's report makes it clear that there was a deficit of £29.8 million and you have no clear idea whether the eight trusts that are currently in deficit will achieve their break-even figures. Does it not concern you that we do not know how we will deal with that issue over the coming financial year?

Mr Jones: No. That is not what I was saying. We have recovery plans for each of those trusts, but I do not have the details in front of me. I would be happy to send them to the committee.

The Convener: The number of trusts in deficit has increased. Will that trend be reversed or will it continue? What do you predict the deficit situation will be next year or in two years' time? Will the number of trusts in deficit increase or decrease?

Mr Aldridge: Our current information is the forecast position of trusts for this year. That may change before the end of the year, so I would not want to suggest that what we have will be the final position.

There is no doubt that a small number of trusts will be in deficit again this year, including the Tayside Acute Hospitals NHS Trust and the North Glasgow University Hospitals NHS Trust, which have substantial deficits that it will take time to get out of their systems. Three or four trusts are forecast to have a relatively small deficit; we are working to ensure that that position is recovered before the end of the financial year, although I cannot be sure whether we will succeed. Other trusts are forecast to break even or have a surplus, although their position may change as well.

If I had to forecast what the position will be at the end of the year, I would say that the combined deficit of the trusts in deficit will be less than it was last year. The number of trusts in deficit will probably be lower, but we will not know that figure until the end of the year.

Nick Johnston (Mid Scotland and Fife) (Con): What responsibility do the health boards have for monitoring the expenditure of the trusts? Mr Aldridge's earlier reply seemed to indicate that the boards are missed out and that the trusts report directly to the Executive. Do the health boards have any statutory responsibility or a monitoring role, or do they stand aside in bemused amazement while trusts go into deficit?

Mr Jones: The first responsibility for health boards is to ensure that their expenditure is contained within their cash limit. That is a statutory responsibility on the health boards. We expect health boards to take an overview of the financial situations in their areas and, when they allocate resources to the primary care trusts and hospital trusts, to take into account the financial circumstances of those organisations. Through the health improvement programme, we expect

financial plans to be produced showing how a health board area will move forward and how the developments and plans proposed in the programme will be financed.

You are right to suggest that, in statutory terms, the formal accountability for a trust's financial performance lies directly with the Scottish Executive—it is not the responsibility of the health board. That is an issue that we will consider in the new finance regime.

The Convener: You accept that there is a gap that must be addressed.

Mr Jones: Absolutely.

Margaret Jamieson (Kilmarnock and Loudoun) (Lab): You have recognised that gap, which I hope the health plan will address.

The details that we have received from the Auditor General show that Argyll and Clyde Acute Hospitals NHS Trust and Renfrewshire and Inverclyde Primary Care NHS Trust were both in deficit. However, in the same financial year, Argyll and Clyde Health Board had underspent by £3.8 million. That does not make sense to the general public, who do not recognise the distinction between the health board and the trusts—the public's view is of the provision of health services in the area.

How can you ensure that the agreement of recovery plans is an open process, given that John Aldridge said that it is the health department, the director of finance and the chief executive who decide them? Where do the public and elected members come into the process?

Mr Jones: I accept absolutely the principle of looking at health boards and trusts in total. As we put together the new finance regime, it is critical that we ensure that we have service plans and financial plans that relate to each other and which have been the subjects of effective consultation with local communities. It is clear that it is the direction in which we need to go.

You cited the income and expenditure position of two of the trusts in the Argyll and Clyde Health Board and the cash position of the health boards. That is not comparing like with like. The income and expenditure position of Argyll and Clyde Health Board was marginally in deficit, to the tune of £273,000. You will be aware of the significant difference between the cash position and the income and expenditure position of organisations. Overall, Argyll and Clyde Health Board area had a deficit of 1.47 per cent. I say that for clarification, but I agree with the principle of managing the total resource of an area. It is right to have sensible dialogue and consult communities about how services are developed and how finances are managed.

Margaret Jamieson: I would like to raise a point of clarification. Exhibit 8 on page 19 indicates that Argyll and Clyde Health Board had an underspend against cash limit of £3.8 million.

Mr Jones: That is correct. Every organisation has a cash position—has it made more cash payments than it has received in a year? It also has an income and expenditure position—do the financial commitments into which it has entered exceed its income? It is quite correct that the Argyll and Clyde Health Board cash position was £3.8 million, but its income and expenditure position was an overspend of £273,000.

I will explain the difference very simply, as this can get very confusing. If, in managing my personal finances, I have £10 in my wallet at the end of the month, my cash position is a surplus of £10. However, if I have an outstanding electricity bill for £40 for that period, I have an income and expenditure deficit of £40. The income and expenditure position is based on one's commitments, whether or not one has made payments. The cash position is concerned with how much one has in one's bank account.

The Convener: If you look at authorities that are in deficit, do you also investigate authorities that are in surplus to find out why? They could be in surplus because they are doing something that everybody else should be copying or because they are doing something inefficiently.

Mr Jones: We look at the total financial position of all organisations. We pay particular attention when organisations are in significant deficit, but we have to consider the overall position.

The Convener: Including value for money.

Mr Jones: Absolutely.

The Convener: We will now address the very modern problem of why the level of clinical and medical negligence claims is rising and what the consequences are of that.

Nick Johnston: Mr Jones, you will agree that negligence claims are a drain on NHS resources. The rising trend in claims, which is shown in paragraph 4.7 of the Auditor General's report, seems to point to problems in the quality of health care that is provided by the NHS in Scotland. Do you have reasons why the claims for clinical and medical negligence are rising?

Mr Jones: There are two reasons why the cash provision for claims is rising. First, we live in a society that is much more likely to sue than was historically the case. More actions will be initiated without anything else in the system changing. Secondly, the level of settlement of some claims is rising. Now, if negligence is proved, settlements can be as high as £2 million or £2.5 million. There are large claims in the system, and more people

seeking to sue.

Nick Johnston: That was a clever answer, but it was not the answer to the question that I asked. I asked how you explain the fact that claims for clinical and medical negligence are rising. You answered that the cash provision is rising, but why are claims rising?

Mr Jones: Because more people are taking action.

Nick Johnston: Obviously, claims have to be met from NHS resources, which therefore are diverted from health care. How do you intend to control this rising tide of claims?

14:45

Mr Jones: This area is quite interesting. When you look at the information in the report, which we have been doing over the past couple of weeks, you see that while the provision that is being made for potential claims is rising significantly, as you said, the actual settlements have been fairly constant, certainly for the past five years, and have settled at about £4 million per year.

It is clear to us—and this is an area that we would like to discuss with the Auditor General—that the basis of establishing the provision needs to be revised. At the moment—and this is based on guidance that we are given—each trust looks at the potential claims that it might settle, puts a cash value on each of those claims, and the total of that list becomes the provision that is made. That is why we have a high provision.

If you look at settled claims, you find that a fairly significant proportion of potential claims do not settle against the NHS, that is, payments are not made. You also find that when trusts are making provision for claims, they are conservative in terms of the figure that they attach to the claim, so they attach to it the highest possible settlement that may occur. In practice, when settlements are made, they tend to settle at a level lower than the maximum. That means that as a service perhaps we are over-providing in that provision, and are allocating cash that could be used for other purposes.

Taken nationally, it is easy to see that trend. It is more difficult to manage it differently within individual trusts, where there are fewer claims and there is less ability to manage the overall position. We would like to discuss that with the Auditor General, and to think about whether we should change the way in which that provision is made. If we get the Auditor General's agreement, we could perhaps reduce that provision. There would be a one-year non-recurring reduction in the provision. Instead of it being set at the level of the worst possible settlement, which is how it stands at the moment, it could be set at a level that is a more scientific estimate of what claims might settle at rather than what the gross potential liability might be.

That is an area on which we need to do more work, and to think about how the accounting treatment works, but it could release a fairly significant sum to address some of the other pressures in the system that we have been talking about.

Mr Aldridge: May I add to what Mr Jones said? He has explained how we might limit the financial pressure on the NHS in future, but I think that Mr Johnston was also asking about the steps that we are taking more generally in the NHS to try to reduce the number of claims that arise. A lot of the claims that are in the system now relate to incidents that happened a long time ago. We have taken steps in recent years, particularly with the development of clinical governance, to increase the awareness of all those who work in the NHS of the need to manage risks and reduce the risk of adverse incidents occurring. That is embedded in the new clinical negligence and other risks indemnity scheme, which was introduced a year ago as the new way of funding clinical negligence claims in the NHS in Scotland. The risk management culture is embedded in that.

The Convener: We are talking about £84.4 million being put to one side, against £4 million in annual claims. That is a massive amount of money that is unavailable for services. Will the clinical negligence and other risks indemnity scheme be enough? How will it operate in practice? Does more have to be done to free up those resources for services?

Mr Aldridge: The answer to that question has two elements. We believe that the clinical negligence and other risks indemnity scheme will help to limit the risks, because every organisation in the NHS will have to meet certain standards in all the areas of its activity, both clinical and non-clinical, to reduce the risk of adverse events happening. It will have an effect, but that in itself may not reduce the financial exposure to claims because, as Mr Jones explained, more people are litigating and making claims, which could have consequences for the NHS.

The Convener: Is there a paradox in that financial problems have to be dealt with, claims arise because of problems in the service and problems arise in the service because there are deficits? Is that a soluble problem?

Mr Jones: I think that it is. If I am correct in my initial assumptions about the provision, we could significantly reduce those deficits anyway. Part of the deficit relates to the provision for clinical negligence, so there are solutions that involve

managing deficits. I do not believe that action is being taken in the service in managing resources that is increasing the risk to individual patients and giving rise to clinical negligence claims. I do not think that that is the case. I would be very concerned if any organisation was taking any action that threatened the safety of individual patients because of the way in which financial resources are managed. I do not believe that that happens.

The Convener: I hope that there is no clash between clinical views and financial views—between what the surgeons would want for clinical reasons and what can be afforded according to the administrators.

Mr Jones: The debate tends to be about how much surgery of a particular type should take place, rather than the issue that gives rise to clinical negligence—how a particular surgeon operates.

The Convener: I will not enter into the Glasgow controversy, but I have read the *Evening Times*.

Nick Johnston: Mr Aldridge, you mentioned that there are improvements in clinical governance. How can you measure those improvements? What standards will you put in place to see whether there is an improvement in clinical governance?

Mr Aldridge: Clinical standards are being developed by the Clinical Standards Board for Scotland, which came into being about a year ago. It is working with the service and with the Executive to determine what those standards should be, and the NHS will then be expected to meet them.

Nick Johnston: What is the time scale for that?

Mr Aldridge: It is progressive. Some standards are virtually on stream now, and others will be developed as time goes on.

Nick Johnston: As time goes on over what sort of time scale?

Mr Jones: We are developing a new performance assessment framework for the NHS. Until now, controls of the service have tended to be financial. We are developing a new performance management framework that will include clinical standards, non-clinical standards and how we manage staff within the service, as well as financial targets. The new performance assessment framework will therefore bring such issues quite directly into the monitoring and control arrangements of the new NHS boards.

You asked when that might happen. We have set ourselves a target of having a description of the new performance management system by the end of April. The intention is certainly to have that operating for the year 2002-03. We need to think about whether any of the elements of the performance assessment framework can be introduced during 2001-02. By 2002-03, the new performance assessment framework will certainly be in place.

Mr Lloyd Quinan (West of Scotland) (SNP): You said that the levels of clinical and medical negligence claims have risen because more people are suing. That gives the impression, which is not borne out in other areas, that we live in a developing litigious culture. Will you indicate whether standards are actually declining—hence the increase in people making claims—or whether, as you implied, we live in a more litigious culture?

Mr Jones: I have seen no evidence to demonstrate falling clinical standards. As a result of the processes that John Aldridge has described, I hope that standards are rising. Nor have I seen evidence to demonstrate increasing mortality rates in particular specialties; the tendency has been towards continual improvement in clinical performance.

Mr Quinan: To what would you attribute the increasing number of claims that are being made?

Mr Jones: I cannot give you a definitive reason for that. It may be that more people tend to take action now.

Mr Quinan: Do you agree that—as Mr Welsh and Mr Johnston hinted—it is the perception of the public that there is considerably more negligence in the health service occurring as a result of underspending? Do you agree that it has little or nothing to do with people choosing to take health boards and health trusts to court because that is the developing culture of this country?

Mr Jones: I have not seen any evidence for that.

Mr Quinan: Why do you think that there has been such an increase in the number of people making claims?

Mr Jones: I cannot express a view on why the public choose to sue.

Mr Quinan: But is the increase in the number of claims purely down to the fact that we live in a culture that is more litigious, or is it because there are failures, which are principally provoked by lack of financial provision in the NHS in Scotland?

Mr Aldridge: The number of claims lodged each year has remained pretty static over the years—about 500 new claims are lodged each year. There has been an increase in the value of claims, not a rising trend in their number.

Mr Jones: In answer to Mr Johnston, I was talking about the number of claims and their value. The table on my briefing demonstrates that the

number of claims is falling, marginally. The value attached to those claims is rising.

The Convener: Do you have any analysis of the type of claim? Has that changed over time?

Mr Jones: I do not have that information but I would be glad to provide the committee with it.

Mr Quinan: It is important that we safeguard public funds by paying only on claims that are justified. Is there a danger that claimants will suffer hardship because claims take far too long to process?

Mr Jones: Until a liability can be demonstrated, it would be inappropriate for the NHS to settle claims without having gone through due process. As one of your colleagues said, if we settle a clinical negligence claim, that expenditure is at the expense of other patient services. It is absolutely right that it should be the responsibility of the NHS to demonstrate that there was negligence before any payment is made. The period that that takes is part of the legal process; it is difficult for the NHS to speed up that process. It would be wrong to rush claims through.

Mr Quinan: When does a patient cease to be a patient and become a claimant? Should the same level of care be extended to them during the period of their claim as when they are in hospital or receiving treatment? In the perception of the trusts or in your perception, does a patient cease to be a patient when they become a claimant, or is the culture one in which the patient remains a patient until the litigation is over?

Mr Jones: For the NHS, the patient remains a patient for the whole of their life. We should always adopt a caring attitude towards all our clients and the whole population.

15:00

Mr Quinan: Do you have performance targets for progressing claims?

Mr Jones: I do not know.

Mr Eric Harper Gow (Common Services Agency): First, I will respond to the earlier part of the question. When liability has been recognised but the amount to pay has not been agreed, we have made payments on accounts to litigants, when much lawyers' work has remained to be done.

In response to the second part of the question, I can say that the court work is taken out of the hands of those who are directly involved and is dealt with lawyer to lawyer, professional to professional. The Common Services Agency hosts the central legal office, so those dealings pass through us. Therefore, the process is one step removed from the patient.

The Convener: Thank you. I am aware that we may be straying from the report. The committee deals not in policy, but in facts and in establishing them.

Mr Quinan: The convener partly covered the other question that I intend to ask when he asked about the efficacy of the clinical negligence and other risks indemnity scheme. Will that scheme provide incentives that are aimed at reducing the incidence of negligence?

Mr Aldridge: Yes. The principle of CNORIS is that an NHS organisation that can show that it is managing its risk and has processes in place to manage and reduce its risks more effectively will receive a discount on its premium every year. Therefore, the scheme provides a financial incentive to improve risk management in the organisation.

Mr Raffan: I was glad to hear Mr Jones say that he had no evidence of falling clinical standards. However, I must ask whether the pressure on clinicians to reach targets on waiting lists and waiting times and bring those figures down rapidly has an effect on treatment. While they are under such pressure, the rate of medical advances accelerates. Clinicians are also under pressure to keep up with constant changes and progression in treatment. Does that make it difficult for them to maintain high clinical standards?

Mr Jones: The first priority is ensuring the highest possible standard of clinical care. That must be the NHS's overriding objective. Mr Raffan asked whether the need to reduce waiting times added to pressure on clinicians. From the public's perspective, it is critical that the NHS reduces the time that people wait for treatment. That is a clear commitment that we must achieve. To do that, we need not always do more, but we must plan how we manage our waiting lists better.

The graph of the number of people who are waiting shows that the majority receive their treatment soon after they are placed on the list. However, there is a long tail of people who wait longer times—perhaps unacceptable periods. We want to get into examining how NHS trusts manage waiting lists and ensure that we address the tail of the waiting list, as well as the bulk of the front end. The public, rightly, find some waiting times unacceptable. We need to address that by considering how the process is managed.

The Convener: Thank you. I would like to make progress. We will now examine financial targets and consider whether they serve their purpose.

Margaret Jamieson: Paragraph 3.10 explains how some trusts met their financial targets by using non-recurring income or funding earmarked for capital. That means that those trusts would otherwise have failed and would have started the

next financial year with an underlying financial deficit. How then do the financial targets provide a true indication of performance and enable comparisons between trusts?

Mr Jones: It is appropriate for trusts to use the total resource available to them to manage their affairs. It is quite right that trusts should use non-recurring income to do that. Equally, trusts have non-recurring expenditure in their accounts. The best example might be the year 2000 issue: £43 million was spent to ensure that there were no problems as a consequence of year 2000. A significant proportion of that money was non-recurring expenditure. It is sensible for trusts to use non-recurring income—ideally to address non-recurring expenditure. That is the perfect solution.

It is also right for trusts to use non-recurring income if doing so gives them more time to create a sensible recovery plan to balance the income and expenditure account. If it does, it is good management to use it. The use of non-recurring income to allow more time to ensure that the organisation's accounts balance is something that I would encourage trusts to do.

We must always consider the total position and ensure that the whole system is in balance or that there is a clear plan to balance the system over time. Those of us at the centre have a responsibility to assist all systems to move towards that position, so that we get the best return from the total investment in the health budget across Scotland.

Margaret Jamieson: The valuation of land and buildings has implications for individual trusts' income and expenditure accounts. One of the trusts in my constituency has expressed concern about this year's financial statement, because the book price of something that has been disposed of leaves it with a deficit of nearly £400,000. What facilities are there to address that? The price that the market will pay for something that has a notional price attached to it is outwith the control of the trusts.

Mr Aldridge: I recognise the fact that several trusts face such issues from time to time. Sometimes, the Executive can do something to help. If there is a book loss on the value of a property—perhaps because the valuation was too high and it achieved a lower price—it is possible in certain circumstances to write off that deficit. However, each case must be considered on its merits.

Scott Barrie (Dunfermline West) (Lab): Paragraph 3.10 also says that Tayside Primary Care NHS Trust and Yorkhill NHS Trust

"anticipated in their 1999/2000 accounts capital receipts due to be available in 2000/01."

Is it right that such things are presented in that way?

Mr Aldridge: It depends on the circumstances. If an organisation knew that a receipt was about to be received at the end of the financial year, it would seem reasonable to include it as income. I would not be particularly happy with that, but a case could be made for including such a receipt. Clearly, if there was simply a hope or an aspiration that the receipt would be received some time in the following year, it would be totally inappropriate to include it.

Scott Barrie: I am not suggesting that, in the two cases that are highlighted in the Auditor General's report, there was anything wrong with anticipating such receipts. However, that practice could be construed as a way of trying to balance the books on paper and so hide the fact that there may be underlying financial difficulties. It seems strange that trusts would anticipate receipts in their accounts. Usually, when organisations present their accounts, they just make a note if anything that is about to happen that might put a different gloss on the figures. Anticipating the receipts suggests something other than the explanation that you gave.

Mr Jones: I do not think that we would say that there was an effort to hide things. The Auditor General is very clear in that particular paragraph that the department's approval of that accounting entry was conditional on there being a plan to demonstrate recurring financial balance in the organisations. It was explicit; it was not about hiding a problem. It was about demonstrating that the entry would be approved only if there was a long-term solution.

Scott Barrie: Was it appropriate to do that in those circumstances?

Mr Aldridge: With the specific conditions, I think that it can be justified.

The point that seems to underlie what you say is that trusts in Scotland have gone to great lengths, for all the best reasons, to hit targets on the nose—to deliver their financial targets exactly. In the Executive, we have been considering whether that creates incentives to do things that may be less than ideal. That is one reason why the Executive is considering revising the financial regime to try to make it more realistic and to avoid any perverse incentives.

Scott Barrie: Last month, the Minister for Health and Community Care published the national health plan for Scotland, which said that many of the measures, targets and systems that derived from the previous internal market were no longer appropriate. Does the department have any plans to review the current financial targets for NHS trusts? Is that the new financial regime that has

been mentioned on numerous occasions this afternoon?

Mr Aldridge: Yes, indeed. The Executive intends to review the financial regime. We hope to be able to make proposals reasonably soon on some short-term changes that may be beneficial and on some longer-term changes that may require legislation. We are still working on the details. As I say, we hope to get rid of any perverse incentives in the existing system.

The Convener: We will move on to how we can get a better understanding and a more comprehensive picture of the overall financial performance of the NHS in Scotland. Again, we have a question from the hard-working Scott Barrie.

Scott Barrie: I want briefly to return to something that has been touched on by a couple of people already. It relates to the way in which the accounts are presented. The accounts show that 15 health boards have a surplus and that eight trusts have a deficit. Given that people think of the NHS as it affects them locally, are not the accounts confusing? Do not they make it difficult for people to work out what is going on in the health service? A story about a trust in financial difficulties will get headlines, yet it seems that money is not as short as it might first appear.

Mr Jones: As I said earlier, health boards are managed on a cash basis. That is in line with Government accounting, but it is changing, because the Government is moving towards resource accounting. Health boards are managed on a cash basis and trusts are managed on an income and expenditure basis. However, the health boards' accounts give their income and expenditure position as well, so we can compare like with like. We have a table that may be useful to the committee. It shows the income and expenditure position of health boards and trusts in each health board area. It gives a feel for the local financial position and I would be happy to share it with the committee. It shows that health boards are not all in surplus in income and expenditure terms. Argyll and Clyde Health Board has a deficit. Borders Health Board has a small deficit of about £111,000. Fife Health Board has a deficit of £1.7 million. On the other hand, Ayrshire and Arran Health Board is £2 million in surplus. Health boards vary: some have a surplus and some have a deficit.

What is critical, as I have said two or three times this afternoon, is that instead of examining individual parts of the NHS system locally we should have an overview of the total financial position of the health care system. Creating the new NHS boards will give us the facility to examine the overall position. The only way to ensure that we get maximum benefit for a local population is to look right across the system.

Scott Barrie: I was going to ask for the officials' view of the true picture of the financial position of the NHS in Scotland, so I think that the figures to which you alluded would be useful in helping us to understand that.

15:15

Margaret Jamieson: The introduction of resource accounting will make things easier for the committee and for members of the public who take an interest in such matters. Do you have any plans to bring that forward for examining the accounts for the whole of the NHS and for what happens at trust level and board level? You indicated that there might need to be legislation. Could you take measures now that might facilitate a step change?

Mr Jones: Some health board areas already manage their accounting systems in an integrated way. That can happen without legislative change. What we cannot necessarily do is impose a statutory target. There is nothing to prevent health board areas from working together to manage the total resource as a single entity to ensure that they get the best return for the amount of money they have available.

The thrust of the health plan takes us in the direction of taking an overall view of health in a specific area. I would encourage local health board areas to do that in advance of implementing the changes that are coming. From discussions with chairmen and chief executives in health board areas, I believe that all the areas that I have been to since I was appointed are moving in that direction. I would be disappointed if that were not the result of the settlement for the current financial year.

Margaret Jamieson: That would be a welcome step forward in ensuring that the process is open and can be understood by the vast majority of individuals in a health board area. It could be part of the public consultation that is alluded to in the national plan. It would be rather foolish for health boards to dig their heels in and say that they will wait until they are forced.

Mr Jones: I agree.

The Convener: We will bring in the patient Mr Eric Harper Gow to discuss the common services agency.

Paragraph 10.6 states that the CSA has had problems in giving accurate information on primary care activity levels to primary care trusts and health boards on a timely basis. That is described as a "critical" weakness in 1999-2000. How can primary care trusts be expected to manage their budgets if such information does not come to them when it is needed?

Mr Harper Gow: As the report says, it is difficult. It is certainly not what we would have wished. We worked hard to improve the situation that we faced. It did not happen as quickly as we would have liked, but it did happen eventually.

The Convener: Without such data, how can trusts challenge GPs to improve prescribing, if they do not know whether it is necessary?

Mr Harper Gow: Information was provided; the problem was that it was not all reconciled as promptly as possible. When people were working with it, they had to treat it as provisional information, because there was no guarantee that it was complete and accurate until the reconciliation process had been completed.

The Convener: We are talking about 64 million transactions and £1.2 billion. Do you agree that the problem was a critical weakness? Can you tell us to what extent the position has improved or deteriorated during the current financial year?

Mr Harper Gow: The volume of transactions involved does not make dealing with the problem easier.

If you wish, convener, we can go into the history of the problems that we experienced during the year under review—1999-2000. The main issue was to reconcile the various contractors' streams with the different budgets, the cash with the income and expenditure elements, and the parties involved—the Executive, the health boards, the primary care trusts and the CSA. That process was remedied for June 2000 payments, after the end of the financial year in question. It was at that point that we caught up and provided the information within six working days, which was the agreed target.

The Convener: Are you saying that there is now reconciliation between the CSA and the health bodies?

Mr Harper Gow: The financial reconciliation process is operating smoothly.

The Convener: The other highlighted problems are inconsistencies in post-payment verification and the absence of a formally documented disaster-recovery test for the GP payment system. The CSA agreed to take corrective action on those problems. What is that action, and is it working?

Mr Harper Gow: I will deal with those matters separately.

Two things happened to the GP-payment system on 1 April 1999. First, we changed the national information technology systems contractor to the Sema Group, which inherited 15 separate systems. In preparation for year 2000 compliance, one of the new contractor's first jobs was to install a new GP-payment system, and it did so during summer 1999. It had to do that work in quite a hurry—the key issue was to keep paying the GPs—and some of the supporting mechanisms were not installed until later. However, a disaster-recovery system, which has been tested twice, is now in place. I am not saying that everything has been attended to yet, but the substantial issues have been addressed.

The Convener: Paying GPs is complex and involves many transactions. Will there be exact reconciliation of the figures and will the system be able to track exactly what is going on?

Mr Harper Gow: Going back to the financial reconciliation of amounts of money, the reconciliation process, which was the issue in 1999-2000, has been addressed.

On the GP payment system, not all the arrangements that one would ideally like in a large and important IT system were put in place immediately. They took time to develop, but they are in place now.

We can go into the reasons for the issues that have arisen during 2000-01 on the management of the prescribing budgets, if you wish, convener. They are not, however, directly associated with the matters referred to in the report.

The Convener: The 1999 Accounts Commission report "Supporting prescribing in general practice" pointed to a range of improvements in prescribing that could benefit patients and generate savings of around £26 million, which is a substantial amount of money. Have such improvements been introduced? Will such a benefit arise?

Mr Harper Gow: Could you refer me to the point—

The Convener: The 1999 Accounts Commission report pointed to a range of improvements in prescribing that could benefit patients to a great extent. Do you agree that primary care trusts are essential for delivering such savings and that good financial information is the key to that?

Mr Harper Gow: I agree with your assertion that primary care trusts are essential. Although we have addressed the issues in the report relating to the previous financial year, other issues have arisen in the current financial year which mean that we still face certain difficulties.

The Convener: I hope that you will report back to the committee on that matter.

Mr Harper Gow: I have no doubt that it will be the subject of audit comment this year.

Margaret Jamieson: Will fully reconciled information for 2000-01 be available on a time scale that will enable audits to be completed in

accordance with the deadlines notified by the department?

Mr Harper Gow: I referred a moment ago to this year's difficulties, which are giving us some cause for concern. We are in discussions with the primary care trusts and other bodies, including the Executive and audit representatives, to address some of the issues that we will face on 31 March. We do not yet have all the answers.

Margaret Jamieson: You talk about the difficulties that you are experiencing. Primary care trusts are charged with providing robust, fully audited accounts by a certain date. As their contractor, you are undertaking work for them and are obliged to supply them with the appropriate information. Are you saying that you will not be able to fulfil your contractual obligations?

Mr Harper Gow: No. I am saying that we have difficulties to resolve and that we are discussing how to do that. Those discussions are not yet complete. We do not have agreement on all aspects, but we are working towards that.

Margaret Jamieson: Was it right to move payment to a centralised system? When it was a local matter, more issues were identified by people living in the communities where they worked.

Mr Jones: Perhaps I should pick up that question. The concept of consistent systems for paying primary care practitioners is right. Before centralisation, there were 15 different systems and interpretations. The audit raised the issue of post-payment verification partly as a result of bringing together 15 disparate payment systems. I have no problem with the principle of using modern technology to put common systems in place, replacing old technology that was coming to the end of its useful life.

With the benefit of hindsight, however, perhaps the timetables were optimistic. Furthermore, the implementation date for the move coincided with the date on which the responsibility for primary care moved from health boards to primary care trusts and the new primary care trusts were created. The operational date might not have been the best that we could have chosen, nor was the time scale the most sensible. However, I say that with the benefit of hindsight.

Margaret Jamieson: I refer you to paragraph 10.6 of the report. If primary care payments represent some 20 per cent of overall NHS expenditure in Scotland, why were steps not taken to ensure that there was a robust system for verification checks from the start?

15:30

Mr Harper Gow: Convener, this is your point about post-payment verification which I did not answer earlier. Mr Jones referred to the fact that centralisation attempted to combine 15 health board systems into one. When centralisation was undertaken, we had the option of carrying on with 15 centres, but managing them centrally, or of combining them and having just one centre. We went for the option of three centres—at least for the time being.

To keep systems going over a short period of considerable upheaval and change—not just in the CSA, but among our customers, the primary care trusts for whom we are the agent—for the most part we carried out checks at the level we had done before and in the same way.

There were two reasons for that—apart from the obvious one that the checking was already being done and was familiar to staff. First, we had to get the agreement of our customer, the primary care trusts. They did not necessarily come to the same view immediately. Secondly, the primary care trusts had to agree everything with their contractor bodies. The primary care contractors include the general practitioners and other parties. We are only the agent of the primary care trusts. It has taken time to develop the post-payment verification arrangements. In the meantime, we have been carrying on with what was there before. There have been one or two adjustments.

Post-payment verification is only part of the process. There are also pre-payment checks. Although we wish to develop post-payment verification into one system which would operate consistently across the country, we must wait for agreement among all parties. That is what we are working towards. Proposals, which have been discussed with the primary care trusts, are about to be shared with the Executive and thereafter with the audit community.

Margaret Jamieson: I am not reassured by your answer. It appears that there is a new internal market involving you—the agent—the primary care trusts and the Executive. You say that you will eventually get round to talking to the audit community. Given that the Auditor General has identified post-payment verification as a particular problem which concerns the expenditure of significant amounts of public funds, your first port of call ought to be to the Auditor General. You should be reporting to him on the general thrust of what you will be doing. Mr Jones would then indicate to the primary care trusts that they need to comply in order to secure the appropriate use of a large amount of public funds. Or is that too commonsensical?

Mr Harper Gow: If my answer misled anyone, I apologise. When I said that proposals are going to the audit community—I think in February—I was referring to written proposals. We have been in discussions with the audit community and the

Executive throughout the process and the discussions are continuing. We are not doing this in isolation. I meant to say that a document containing formal proposals for a consistent, unified system across the country will see the light of day next month. We must then go from the plan to implementation. Obviously, that will not happen by next weekend.

The Convener: Thank you for that clarification. I invite Paul Martin to take up the matter of post-payment verification.

Paul Martin: Do you agree that practice visits are an important part of the post-payment verification system, as covered in paragraphs 10.6 and 10.9 of the Auditor General's report?

Mr Harper Gow: I agree that practice visits can be part of post-payment verification, but they are only one element of it. They also serve other purposes. There are still some differences of opinion as to whether they represent value for money, but we think that they have a place. You asked me whether I thought that they were an important part. I would not want you to get the impression that they were more important than anything else, because they would not necessarily come top in the pecking order.

Paul Martin: But are they important—yes or no?

Mr Harper Gow: They have a role.

Paul Martin: To be fair, the question whether they are important is quite simple. Yes or no?

Mr Harper Gow: They have an importance, yes.

Paul Martin: So they are important.

Mr Harper Gow: They are important.

Paul Martin: But you have qualified that by saying that there are other measures. How many verification visits have been carried out in each health board area?

Mr Harper Gow: There are three CSA practitioner services regional offices, one of which is in Edinburgh and covers the east of Scotland. We visited 54 practices over a period of months and, as I said, we had some concerns about whether that represented value for money. Only £200 was recovered.

Paul Martin: I asked about each health board area. Forgive my ignorance on this matter, but how should I divide that total of 54 practices?

Mr Harper Gow: We do not visit general practices every year, and that has never been the plan. As I tried to explain before, the visits are one element of the range of measures that we group together and call post-payment verification. There will be proposals for two types of visit: those that are indicated by statistical analysis and other intelligence, which will be very targeted; and a small number—probably about 1 per cent—of random visits. I do not have information to hand about the total number of visits that have been made so far in this financial year, but I can obtain it and make it available to the committee.

Paul Martin: You said that there were 54 visits. Was that the total for all the health boards?

Mr Harper Gow: No. The Edinburgh office made 54 visits for the health boards that it covers. That was not the total number for the whole country. I will have to obtain that information and pass it on to you.

The Convener: That would be appreciated.

So far, many of your answers have been about gathering financial information, but I would like to know about the quality of the information regarding internal financial control. I was worried that the Auditor General's report said that there were weaknesses in most of the 50 NHS bodies. For example, the report identifies

"The absence of a fully developed risk management strategy . . . The absence of a formal fraud and corruption policy . . . The need to develop IT security policies . . . under the national IS/IT service provider contract and information management and technology strategies."

According to the report, central payroll systems had

"Limitations in the amount of audit assurance available".

The report goes on to list

"Weaknesses in the control of payments relating to Family Health Services . . . The need to update Standing Financial Instructions and schemes of delegation."

I know that action plans exist, but those are quite serious matters. What is the current progress of the action plans and when will those problems be sorted out?

Mr Jones: I have a schedule showing current progress under each of the main headings that were identified as issues from the internal control statement. I could go through that statement now, or I could supply a copy of it to the committee.

Eighteen trusts did not have a risk management strategy and they are working on such strategies during 2000-01. One trust's risk management strategy has been approved already. Eight trusts did not have a policy on fraud and corruption, but five have now introduced such policies and three are in the process of preparing them. We have a report that measures progress against each of those tasks.

The Convener: We have been going for some time, so rather than go through the statement now, I would appreciate it if you would send it to us following the meeting.

Mr Jones: We will do that.

The Convener: We will move on to the last section, which is on the European Union working time regulations.

Nick Johnston: In paragraph 11.9, which is on page 32 of the report, we are told:

"The Department wrote to health bodies in April 2000"—

about the EU working time regulations, although they have been in force since October 1998.

Why did most NHS bodies not implement the regulations when they came into force in 1998? Did you realise that the regulations set out a legal requirement?

Mr Aldridge: We had a clear understanding that there was a legal requirement to comply with the EU working time directive. However, the extent of that liability was not clear and there was, shall we say, legal discussion about that. The exact effect of the directive on the pay of NHS staff in Scotland was not clear, which is why payments to staff were not made until this financial year.

In light of information received from external auditors who were concerned that provision had not been made by every health service body against their potential liability under the directive, and following discussion with Audit Scotland, we wrote to the health bodies in April 2000 to say that they should make such provision. During summer 2000, once the legal position in Scotland had been clarified, health bodies proceeded to make those payments and in September the Executive issued £20 million to the health service to cover those back payments.

Nick Johnston: Sorry—could you clarify whether you are saying that NHS bodies did not realise that they would have to implement the regulations?

Mr Aldridge: They knew that they would have to implement the regulations, but the extent of their liability was not clear.

Nick Johnston: Why did not they implement the regulations when they came into force?

Mr Aldridge: Because the way in which the regulations needed to be applied was not clear.

Nick Johnston: In paragraph 11.11, we are told that the regulations could cost the NHS £15 million. What is your latest estimate of the final figure? How much has been paid out so far?

Mr Aldridge: The arrears, which go back to 1998, were estimated at £15 million in the provisions that were entered into the accounts for 1999-2000. As I said, in September last year the Executive issued £20 million to the health service to help it meet those costs. The final cost is not known yet as some of the health service bodies are still working through the details of what the directive is costing them. It appears that the backlog costs will probably come to an amount that is not significantly different from the figure that we made available. However, there will be a continuing cost, which will work through the accounts of health bodies in future years.

Nick Johnston: Has the £15 million been paid out now?

Mr Aldridge: Yes.

Nick Johnston: The costs arising from 1998 have been paid.

Mr Aldridge: Yes.

Mr Raffan: I will return to the recovery plan, as I am still worried about a point that was made earlier. We all know that there is an uneven spread of services and treatment among different health board areas. I have an interest in the area of drug misuse and can cite the example of Ayrshire and Arran Health Board, which has a relatively good service, while Fife Health Board, which is in my region, does not have a good service.

Despite Mr Aldridge's statement—he will correct me if I am wrong—that the recovery plans, which will bring health bodies back on to the financial track within the shortest period of time possible, will not damage patient care, I am worried that the recovery plans will deepen that unevenness. There will be a bigger difference, if you like, between the services that are available in one health board area and the treatment that is available in another area. Rather than the service becoming more uniform throughout Scotland, it will become less uniform.

15:45

Mr Jones: Funds are allocated to health boards based on their populations' assessed need. If trusts in a health board area manage their resources tightly and never go into deficit, the range of services that they offer their population will be in balance. For whatever reason—and we have a schedule of things that may contribute to a deficit, such as unplanned developments—trusts in another area may bring new services into the equation that cause overspend.

There is an interesting debate over whether we should take funds from those parts of the Scottish health system that maintain their service in financial balance and use them to fund the deficits in other areas. I think that that is what you are asking about.

The important thing to remember is that, although the NHS system allocates resources to health boards based on the assessed need of their populations, it is within the local system that

people decide how to use those resources.

I am not sure whether this is what you are suggesting, but it might not be sensible simply to clear or fund deficits from the centre, because that money would come out of the fixed pot of the health resource. It would therefore be done at the expense of other health board areas.

There is a fine balance to strike between offering central support for areas that are in deficit and recognising that, if an area has maintained itself in financial balance, it should be complimented rather than penalised. The issue is complex and not quite as black and white as I have painted it, but I hope that I have given you a feel for things.

We have taken decisions to put as much money as possible into local health systems rather than holding central reserves for contingencies that may occur. When we do that, there has to be a responsibility on the local health systems to manage their own affairs and to deal with contingencies locally. We will wrestle with the equations when we think about the finance regime. However, it would be wrong to do anything that penalised areas that are in financial balance.

The Convener: I had planned to ask for any final comments, but I think that we have just had some. This market day is wearing late indeed. We have dealt with a wide range of topics and we appreciate today's replies to our questions and the promise of further information. I thank Mr Trevor Jones, Mr John Aldridge, Mr Eric Harper Gow and their colleagues who were here to assist them.

15:47

Meeting continued in private until 15:57.

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