AUDIT COMMITTEE

Monday 2 April 2001

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AUDIT COMMITTEE
6th 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

THE FOLLOWING ALSO ATTENDED:

Brian Adam (North-East Scotland) (SNP)
Mr Robert Black (Auditor General for Scotland)
Kate MacLean (Dundee West) (Lab)
Mr John McAllion (Dundee East) (Lab)
Irene McGugan (North-East Scotland) (SNP)
Shona Robison (North-East Scotland) (SNP)

WITNESSES

Mr John Aldridge (Scottish Executive Health Department)
Mr Peter Bates (NHS Tayside)
Mr Tim Brett (Tayside Health Board)
Mr Trevor Jones (Scottish Executive Health Department/Chief Executive of the National Health Service in Scotland)
Mr Tony Wells (Tayside Primary Care NHS Trust)
Mr Paul White (Tayside University Hospitals NHS Trust)

CLERK TO THE COMMITTEE

Callum Thomson

SENIOR ASSISTANT CLERK

Anne Peat

ASSISTANT CLERK

Seán Wixted

LOCATION

Dundee City Council Chamber

Scottish Parliament

Audit Committee

Monday 2 April 2001

[THE CONVENER *opened the meeting in private at 10:03*]

10:31

Meeting continued in public.

National Health Service (Tayside)

The Convener (Mr Andrew Welsh): I formally open the meeting in public. I say a big thank you to the staff of Dundee City Council. Even though today is, I believe, a Dundee public holiday, the staff have turned out. We much appreciate their assistance.

This is the first meeting of a Scottish Parliament committee in Dundee. The Audit Committee thought it important that this meeting should take place in Tayside, due to the widespread concern about the running of the national health service in Tayside in recent years. The committee welcomes the high level of public interest in this subject, which is evident in the number of tickets that have been taken for seats in the public gallery.

Members of the public should be aware that this is a formal meeting of the Audit Committee. Members of the Scottish Parliament will take evidence on issues that arise from the Auditor General's report "National Health Service bodies in Tayside". It is not appropriate for members of the public to intervene. I will insist on, and greatly appreciate, the public's co-operation in ensuring the proper conduct of business today.

I welcome members of the committee. There are no apologies, as all committee members are present. Other members of the Scottish Parliament are attending. Although they are not members of the Audit Committee, our parliamentary colleagues are welcome to attend and to participate. This morning we have with us Irene McGugan, Shona Robison, John McAllion and Kate MacLean, who is in her old stomping ground of Dundee City Council chambers. I also welcome the Auditor General and his staff, as well as the witnesses and the members of the public, to this historic first meeting of the Scottish Parliament in Dundee.

So that everyone knows what is happening, I inform the meeting that the committee will explore the issues behind the financial difficulties of the NHS in Tayside in recent years and will look at the respective roles of the Scottish Executive and Tayside health bodies in resolving them. I point out that the Audit Committee is different from other parliamentary committees, because we deal not in policy, but in the facts of the matter, on which we make recommendations for improvement in the future. Finally, I remind everyone to switch off their mobile phones and pagers.

Before we come to the evidence-taking session, I must deal with a matter of committee business. Is it agreed that we hold agenda items 4, 5 and 6 in private?

Members *indicated agreement.*

The Convener: We now come to the evidence-taking session. This is the first occasion on which the committee has taken evidence on the NHS in Tayside, based on the Auditor General's report on NHS bodies here. I understand that the facts in the Auditor General's report have been agreed by the witnesses.

The witnesses who are giving evidence to the committee today are Mr Trevor Jones, head of the Scottish Executive health department, and his colleague Mr John Aldridge, the director of finance of the health department. We also have with us Mr Peter Bates, the recently appointed chairperson of the NHS in Tayside. Mr Bates is accompanied by his colleagues Mr Tim Brett, the chief executive of Tayside Health Board, Mr Paul White, the chief executive of Tayside University Hospitals NHS Trust, and Mr Tony Wells, the chief executive of Tayside Primary Care NHS Trust. You are welcome, gentlemen. You will notice that we have invited representatives of every level of decision making, from the national to the specific in Tayside.

I wish people to be clear about the format of the meeting. We are dealing with the following issues: first, accountability within the NHS in Tayside in general and the role played by the Scottish Executive health department; secondly, the causes of the financial problems experienced by Tayside Health Board and the action that is being taken to resolve them; thirdly, the financial implications of health care in Tayside, including progress in implementing the Tayside acute services review; and, finally, the Tayside health bodies' approach to governance, leadership and communication and the steps that are being taken to improve those key issues.

I understand that Mr Peter Bates would like to make a short opening statement.

Mr Peter Bates (NHS Tayside): Convener, thank you for giving me the opportunity to make a brief statement. As you have said, there has been concern about the health service in Tayside for many years. Indeed, the service's history may be described as turbulent, with many consequences,

including, sadly, a loss of trust, particularly in the health board and some constituent parts of our health service. However, in approaching this agenda, we must remember that we have an outstandingly good health service here and a dedicated and committed work force. It is important that we learn from the past so that we can focus on the future.

I have spent the past 10 weeks with a number of our consultants, nurses, doctors and general practitioners, with representatives of community groups, patients and local government, and with many others. If I have found one common thread, apart from huge dedication and commitment, it is that there is concern and—I must advise the Audit Committee—loss of morale about the fact that Tayside health service is continually presented as failing. We have to reverse that. I feel strongly that that is a key challenge that I have been set.

On behalf of NHS Tayside, I welcome the Auditor General's report, which is fair, measured and accurate. I wish to record formally my appreciation for the way in which the Auditor General and his staff went about preparing the report. Given the nature of some of our difficulties in Tayside, that process could have been damaging, but it was not.

As a very newly appointed chairperson on a very steep learning curve, I am determined to lead a process of continuing recovery. Although change has started and will continue—as it needs to do—we face many challenging decisions, as the Auditor General's report covers very well. Indeed, those decisions probably needed to be taken a long time ago.

Tayside Health Board needs the support of MSPs, the media, the Executive, the Auditor General and many others to continue the process of recovery. We have made the first steps in a long and complex journey, which must continue in the right direction. That journey is built on the two key principles of far greater honesty and far greater transparency, which is the spirit in which we will approach answering questions and entering into dialogue today.

The Convener: The committee expects—and will appreciate—honesty and transparency. Committee members and the general public well understand your comments about the dedication of the staff, which accounts for the exceptional interest in today's meeting.

My first questions about accountability at the national level are addressed to Mr Jones. Paragraphs 2.1 to 2.5 of the Auditor General's report describe the key roles and responsibilities of the NHS. Can you explain the lines of accountability that have operated between the chief executive of the NHS nationally and the chief executives of the health boards and trusts? What are the strengths and weaknesses of those arrangements?

Mr Trevor Jones (Scottish Executive Health Department/Chief Executive of the National Health Service in Scotland): First, I should point out that those relationships are changing, so if I describe the history, it might also be useful to describe how the new world will look.

Before the Scottish Parliament was set up, chief executives in the NHS were accounting officers and sub-accounting officers to the chief executive of the management executive in Scotland. As a result, the chief executive of the management executive was the principal accounting officer, with the NHS chief executives acting as sub-accounting officers for the spend within their area. With the Scottish Parliament, that relationship has changed. All chief executives in the NHS in Scotland are accountable officers reporting directly to the Parliament.

NHS organisations are obviously accountable to the Minister for Health and Community Care for the performance of their business and for the strategic direction that has been set for the NHS in their area. They are monitored on their performance by the health department, which is responsible for issuing guidance to the organisations to allow them to conduct their business.

The Convener: Who is in charge? Clearly Tayside health services are in a mess, and have been in one for many years. Tayside is the worst-case financial scenario in Scotland. Who is in charge? Is it the health department, the chief executives of the boards and trusts, or both?

Mr Jones: Ultimately, the minister is responsible for the overall direction of the NHS. As principal accountable officer, I am responsible for the £5 billion health service spend. However, NHS organisations are separate corporate bodies, and their chief executives have a direct line to Parliament about how they conduct their financial business.

You said that NHS Tayside was in a mess. It is worth putting its position precisely into context. Although there have been problems, which we will talk about later this morning, I should point out that our best estimates of the financial performance in the past financial year—ending on 31 March 2001—is that NHS Tayside has an overspend of 2 per cent of its budget. In other words, although there are still some problems, which are being addressed, NHS Tayside is running at a 2 per cent deficit on its overall expenditure.

The Convener: However, we are still talking about £11.1 million and the worst record with regard to return on capital.

Mr Jones: Yes, indeed.

The Convener: The health department gives £400 million to Tayside authorities. What is to prevent the situation from recurring?

10:45

Mr Jones: We are now putting in much stronger lines of performance management and accountability to the NHS. The committee will be aware that we issued "Our National Health: A plan for action, a plan for change" in December; it might be worth spending a couple of moments describing the service's new accountability and performance management arrangements.

We are creating 15 new NHS boards, which will be responsible for setting the strategy for an area, for allocating resources to all the NHS organisations within the area and for managing performance. The composition of those boards will include the chairmen and chief executives of all the NHS organisations in the area. As a result, a single boardroom will be responsible for the corporate management of the NHS in an area. That important change will ensure a single agenda, with resources managed to best effect for a particular population.

We are in the process of appointing new chairmen to those NHS boards; we have already appointed two—one to Fife, and Peter Bates to Tayside—and the other 13 are being appointed. We want strong leaders to manage the corporate business within an area.

We are also moving away from having separate lines of accountability between NHS trusts and health boards and the Scottish Executive. Under the new arrangements, there will be a single local health plan for an area, which will demonstrate not only that national priorities and local issues are being addressed but that all plans are affordable and that resources are being used to best effect in an area.

Furthermore, we are introducing a new performance assessment framework for the service, which will address the whole business of an NHS board. As well as addressing financial and efficiency issues, the framework will address how a health board is implementing the health improvement agenda for its population, how it is tackling issues of clinical quality and governance, how it involves the public, how it works with its key partners in the area, principally the local authorities, and how the NHS board manages its staff. That last point is important; as 136,000 people are employed in the NHS, we must send strong messages about how staff should be governed.

We will set targets and performance measures in each of the areas that I have described and annually publish every health board's performance against those targets to ensure a public demonstration of the overall performance of a health system.

We are also introducing a new, simplified finance regime that will move away from one or two of the remnants of the internal market in the existing finance regime and allow us to take a whole-system approach to managing health service resources within an area. We want to move away from the current situation in which, in some health board areas, one organisation might be in deficit and another in surplus. We want the resources to be managed to best effect for the population through the finance regime.

The Convener: You are in full flow; however, the answers are getting rather long. As I do not want to pre-empt future questions, I would like answers to be as clear and as succinct as possible. I am falling into my own trap by tempting you into giving such long answers.

Your department gives £400 million to the Tayside health organisations. What powers do you have to issue instructions or to take direct action if you have serious concerns about management or performance in a health board?

Mr Jones: We have a series of escalating interventions. For all health boards, there is a routine monitoring process to demonstrate how a health system is performing. If there were particular concerns, the minister could issue a direction to a health organisation through Parliament. Finally, if the concerns were very serious, the minister could replace the board of an NHS organisation.

The Convener: Sending in a task force, or replacing a board or a chairman, is closing the stable door after the horse has bolted. It is the disaster scenario.

To quote from the Auditor General's report, "National Health Service bodies in Tayside", the department's role is

"to set strategic aims … to issue guidance … on the organisation and management … including corporate governance arrangements."

However, the Kilshaw inquiry report showed that the health department failed to ensure high standards of corporate and personal conduct. For example, only three or four years ago, Tayside Health Board officials were trying to interfere with audit reports. The Kilshaw report also says that

"independent scrutiny … has repeatedly identified weaknesses in … leadership, governance and communication."

The health department has failed to fulfil its role. What is being done to sort that out? What

guarantee can you give us that it will be sorted out?

Mr Jones: With respect, convener, I do not agree that the health department has failed to fulfil its role. As problems have been identified, action has been taken. In Tayside, there is direct action in the form of the recovery plans that are now in place to put finances on a sound footing.

As for the Kilshaw report's recommendations, we asked the auditors to visit every health organisation to ensure that problems similar to those that had been identified in Tayside were addressed. Following that intervention, we received a positive report from the auditors. I do not think that we failed. We took action.

If we consider the financial situation in Tayside, the problem escalated relatively quickly—from March 1999, when the former NHS organisations in Tayside were demonstrating, through their accounts, that they were delivering on financial targets, to the early summer of that year, when a significant deficit was being forecast. From that point, we worked closely with the NHS in Tayside to ensure that recovery plans were in place. I am pleased to say that the first two phases of that recovery plan have been delivered.

The Convener: There were continuing problems over many years. I am trying to find out what mechanism exists centrally to do something about problems.

I quote from the Auditor General's report again, which says that the end products of accountability review meetings are

"a summary of the key issues"

and

"an indication of the broad actions expected by the Department in the year ahead."

Given the NHS's past record in Tayside, and its current financial performance, is the departmental response good enough? What will your department do to tighten up its accountability reviews and procedures?

Mr Jones: I will not repeat the new performance assessment framework because I ran through it in some detail. That new framework will prevent some of the problems that you describe. We are putting in place a new accountability review mechanism for the new NHS boards, which will lead to a much more focused process for NHS organisations to account to the health department.

Kate MacLean (Dundee West) (Lab): I welcome what you have said about the new performance assessment framework, which will be much more robust.

I would like you to clarify your answer to the convener's first question about who is in charge. You said that the minister was in charge. Obviously, the minister has ultimate responsibility. However, if the chief executive of the management executive is the principal accounting officer, and the chief executives of the board and the trust are the sub-accounting officers, who is in charge of financial management?

Regarding your response to the convener's second question, if the chief executive of the management executive was aware that there were problems going back over a number of years, why was action not taken sooner? I realise that you were not in post at the time so I suppose you are in the fortunate position of not being held accountable today.

Mr Jones: Let me repeat that NHS organisations are separate corporate bodies. Their officers are directly accountable to the Parliament for the funds allocated to them to manage health services in a local area. Therefore, the local NHS organisation is accountable for detailed operational management and its chief executive is accountable directly to Parliament, not to the chief executive of NHS Scotland.

However, as chief executive in the health department, I am accountable for the full health spend—£5 billion of expenditure. I am not pretending that I do not have responsibility. That is why it is essential that we have tighter accountability arrangements in the NHS. The new performance assessment framework will, I think, provide us with that vehicle.

The Convener: The Auditor General's report says that the central mechanism used by the department to hold health boards and trusts to account is the accountability review meeting. How often do those meetings occur and what is discussed?

Mr Jones: There is a formal accountability review meeting once each year, which reviews the performance of an NHS organisation over the previous 12 months and agrees action that should be taken and an agenda for the coming 12 months.

The Convener: Are performance and financial management issues considered in detail and are full records kept?

Mr Jones: Following the meeting, a formal letter is issued from the chief executive of the NHS to the chairman and the chief executive of the health board. The letter records the issues that were agreed at the meeting.

The Convener: Let me see whether I have got this right. You have an annual accountability review meeting—one per board area—at which general issues are talked about, but no full record

is kept and afterwards only a letter is sent out.

The health department's role is to

"monitor the financial and other performance … through regular performance returns and … Review meetings"

and

"to issue guidance … on the organisation and management … including corporate governance arrangements."

Despite that, we see in paragraph 18 on page 6 of the Auditor General's report, with regard to the £11.3 million Tayside University Hospitals NHS Trust deficit, that

"The 1999 Annual Accountability Review meeting did not address in any detail these financial pressures upon TUHT in the first year of its existence."

We then find that the 2000 review did not even take place. Did any of that fulfil the department's obligation to

"monitor the financial and other performance"?

Mr Jones: I cannot comment on those accountability meetings. I was not there, so I cannot comment on the detail of the discussions. The letter that confirms the agreements reached at the meeting sets out all the actions expected of an NHS organisation. It is important to stress that, at the end of the financial year 1998-99, all the NHS organisations in Tayside were demonstrating the delivery of their financial targets. The real problem occurred when the new management team came in to TUHT and identified financial problems between May and July 1999.

The Convener: It is not very satisfactory to be told in February that all is well and then in July that all is wrong. Do the accountability review meetings highlight performance and financial management problems? Clearly, in the case that you describe, they did not.

Mr Jones: They do—if significant problems are identified. We have a monthly monitoring arrangement with each NHS organisation. John Aldridge will perhaps describe that, as he manages that part of the office. There is a detailed monitoring process that identifies the status of each NHS body.

The Convener: But it did not. The approach is rather hands-off. Given the problems that have occurred, and given previous management difficulties, I would have thought that central Government would have some ability to spot problems before they started. Otherwise, £400 million is being handed out, the stewardship of which is not especially good.

Mr Jones: There is a monthly monitoring process. Mr Aldridge will describe how the problem was identified. As I said, that ran through from May 1999 to the July monitoring report.

Mr John Aldridge (Scottish Executive Health Department): In addition to the annual accountability review, there are regular meetings—both on the wider performance management agenda and on specific financial performance issues. Those meeting take place regularly throughout the year. They identify problems and we try to work with the local NHS organisations to resolve them.

You drew attention to paragraph 18 on page 6 of the Auditor General's report. It points out that the department, at the time of the accountability review, pressed the health board and the trust to prepare a viable financial framework for 1999-2000 as a matter of urgency. That is why the issues were not discussed in great detail at the accountability review itself. Because of the information that we had, we were concerned that a viable financial framework was not in place. We had the opportunity to press the local organisations to prepare such a framework.

The Convener: What guarantees can you give that such a situation will not recur?

Mr Aldridge: We can never guarantee that parts of the NHS will not have financial problems from year to year. It would be wrong for me to guarantee that. However, as Trevor Jones explained, we are introducing a new performance assessment framework. The new financial regime is designed to reduce the chances of such problems arising again.

The Convener: Can the committee have copies of the records of the department's annual accountability review meetings with NHS bodies in Tayside?

Trevor Jones: Yes.

Mr John McAllion (Dundee East) (Lab): I would like to follow up the previous question. Paragraph 18, on page 6 of the Auditor General's report, mentions that your department urged the trusts

"to prepare a viable financial framework".

Did you do that in March 1999?

Mr Aldridge: By the summer of 1999.

Mr McAllion: In February 1999, Tayside Health Board submitted the financial framework, which the management executive approved.

11:00

Mr Aldridge: On the basis of the information that we were given at that time, we accepted that financial framework as the correct position. Early in 1999-2000, it became clear—as Trevor Jones explained—that problems were arising. Indeed, that became clear from our monitoring.

Mr McAllion: How did it become clear? It seems to me that the management executive was entirely dependent on information provided by the boards and trusts. If the managements of the boards and trusts have completely the wrong information, you get bogus information on which to base your assumptions.

Mr Aldridge: To a large extent, you are right.

Mr McAllion: Any system that depends on local management is suspect if that local management gets it wrong. You should have a different way of dealing with this.

Mr Jones: If we want an NHS that is responsive to local need, we must have organisations that have the ability to manage locally. We must have effective monitoring processes in place—

Mr McAllion: That is the point. How can the monitoring system be effective?

Mr Jones: Trying to micromanage the whole of the NHS from St Andrew's House would not be the right direction to go in.

The Convener: To micromanage is one thing, but what about macromanaging, which should be your job?

Mr Jones: We are bringing in the new performance assessment framework, so that we can gauge the effectiveness of each health board area. We will manage the seven fields that I described. That will demonstrate whether health boards are effectively managing the whole of the business—including finance and other areas. That will allow us to identify weaknesses or areas that require attention.

The Convener: That leads us neatly on to the question of whether the health department could have done more at the time to resolve the emerging financial difficulties in Tayside.

Mr Keith Raffan (Mid Scotland and Fife) (LD): Mr Jones, no one expects you to micromanage, but we do not expect you to pass the buck either. Mr Bates hit the nail on the head—we are raking over the past because we are looking to the future, so that we can avoid such a situation recurring.

In February 1999, the health department was given Tayside Health Board's financial framework. The convener was being generous when he said that the finances were all right in February and all wrong in July. By April, it was in fact pretty clear that things were going badly wrong. Why did the alarm bells not start ringing within two months of your receiving that financial framework? Why did you not intervene or take some action?

Mr Jones: I do not think that it was clear in April 1999 that there were major problems. There was a new management team—

Mr Raffan: Sorry, I will intervene before you go any further. We want succinct answers. To avoid my having to come back to you straight away, let me quote from the Auditor General's report. Paragraph 6.3 makes it quite clear that TUHT

"expressed concerns about its financial position in April 1999".

If it was expressing concerns, it was clear that something was going wrong.

Mr Jones: No. Look at the monitoring returns that were coming in. In July 1999, the trust was forecasting a 3.1 per cent deficit in its monitoring return, but the trust indicated in the narrative to the report that the figure could rise as high as £10 million. The department received that return in August and from September the department was working with the trust on a recovery plan to address that issue. In fact, the trust had already put measures in place to reduce its overspending.

The first draft of the detailed recovery plan was with us from November. In August, we received the monitoring report, which indicated a significant problem; in November, we received the recovery plan, which was refined. We then had concerns about the deliverability of that recovery plan and in February 2000 the minister announced the introduction of the task force. Action was being taken by the trust as soon as it was aware of its financial problems.

Mr Raffan: The question is whether action was taken as soon as possible. From the Auditor General's report, it appears to me that the department was dilatory. The TUHT was expressing concern by April 1999; things had seriously deteriorated by July; you received the report in August; then there was a meeting in September; then the board sent the trust away to draw up a recovery plan by the end of October; then you had a meeting in November. There does not seem to have been a huge sense of urgency when things were going seriously off the rails. Should you not have intervened earlier?

Mr Jones: Hindsight is a wonderful thing—

Mr Raffan: We are trying to learn from the past, are we not?

Mr Jones: Absolutely. If one asks whether, with hindsight, the department could have intervened earlier, the answer is, "Yes, we could"—

Mr Raffan: Is it not, "Yes, we should have"?

The Convener: Please allow the witness to answer.

Mr Raffan: Sorry. Is it not, "Yes, we should have"?

Mr Jones: I think that you are right. The new performance assessment framework will address

that. We have learned from our experiences and have designed the new performance assessment framework to address the whole of the business and produce a much tighter accountability framework for the NHS. That is already happening.

One should not assume that nothing was happening between the point when the trust expressed concerns about the financial pressure that it faced and the point when the task force came in to help the NHS in Tayside. Right through the summer of 1999, the trust was taking significant action to identify ways to address the deficit.

Mr Raffan: No one is saying that nothing was happening. The question is whether it was happening quickly enough and whether there was sufficient sense of urgency.

Does Mr Brett feel that earlier, more detailed intervention would have helped the trust to find workable solutions to address the concerns, which the trust had made clear as early as April?

Mr Tim Brett (Tayside Health Board): I am sure that that would have helped. As Mr Jones has already said, three of the four previous trusts had met their financial targets. Everybody was a bit taken aback by the scale of the problem that we faced. We knew that in Perth and Kinross we had a serious problem from the previous year, which we had addressed as part of the February plans. Because the other trusts had met their targets, we assumed that the new trust would be able—albeit with some difficulty—to deal with the problems.

Mr Raffan: To what extent did Tayside Health Board ask the health department for help? To say that you were taken aback makes it sounds as if you were in a state of slight shock. Why did you not approach the department earlier?

Mr Brett: Both trusts approached the department to look for assistance.

Mr Raffan: When?

Mr Brett: I think that that was in May 1999. Both chairmen wrote at that time.

The Convener: It bothers me that problems were detailed in the Kilshaw report and clear warnings were given about financial and other problems, yet the department seemed to stay aloof. The signals were clear. The department does not seem to have the powers or the mechanism to get to problems before they reach the crucial stage, when task forces need to be sent in.

How does Mr Jones feel that the department fulfilled its responsibility to monitor the financial and other performances of the trusts and boards to which it gives £5 billion each year? Those problems are in the past, but can you guarantee that the future will be any better?

Mr Jones: I can certainly guarantee that the future will be better. I have described the mechanisms that we are putting in place to ensure that. One cannot guarantee that NHS organisations will not face financial problems. However, the control mechanisms are being significantly strengthened.

The Convener: We will now look at the guidance that the department gives to health bodies.

Margaret Jamieson (Kilmarnock and Loudoun) (Lab): Why was it that, three months after the financial recovery plan was received from Tayside health bodies, Mr Jones felt the need to issue guidance on what he expected from health bodies?

Mr Jones: The guidance was not about what we expect health organisations to do. It is absolutely clear that we expect health organisations to provide quality health services within the resources available to them. Local health bodies must manage their resources effectively.

We issued guidance on the detailed information that we required to ensure that the problem was being addressed effectively. The guidance was not about action. All organisations within the NHS know what is expected of them—they must ensure that they are providing services within the resources allocated to them. I do not think that any NHS managers need guidance about that—they all understand that simple concept.

Margaret Jamieson: So, the guidance that you issued was specific to Tayside and was not given to other health authorities?

Mr Jones: The guidance concerned the type of information that we required to ensure that the problem was being addressed; it was not about the need to live within resources. That is the important point, which is widely understood. It is for local health services to identify the solutions to manage their resources.

Margaret Jamieson: Did the fact that no clear guidance was given on the department's requirements for financial recovery plans contribute to the problems? Did that deflect efforts to find a solution to the problems? Could Mr White address that question?

Mr Paul White (Tayside University Hospitals NHS Trust): I am happy to answer that question. The problem that we faced was of enormous magnitude, and it shocked me when I realised what we had walked into in Tayside. Four of the executives who came to Tayside, including me and the director of finance, had not previously worked there. We received assurances that the

trusts had balanced their books, with the exception of Perth and Kinross Healthcare NHS Trust, which we knew had used one-off moneys. What was totally unapparent to us was the extent to which non-recurring funds had been used throughout Tayside to support recurring costs and the extent to which new service developments had started in the latter part of 1998-99. The full-year cost effect of those developments hit us at the end of the first quarter of the new trust.

We immediately set action in train. The concept of working within financial regimes and to these targets was not foreign to me, or to my director of finance; we had managed a trust in Dunfermline for five years and had consistently met our targets without recourse to non-recurring funds. The extent to which such funds were used in Tayside was a shock to us. I knew what we had to do, and the executive team was clear about the magnitude of the task that faced us. We immediately set about alerting budget holders, senior clinicians and senior managers in the organisation to the fact that we faced a very large problem.

We were hopeful that the problem was not as big as the early figures indicated and we doubted whether the split of the previous trusts had been undertaken correctly. As the Auditor General indicates, Tayside faced the most complex of reorganisations, with two existing trusts being split between the two new trusts. Our first reaction was to question whether there had been an error in the apportionment of budgets. Research into that was quickly carried out and it became evident that no such error had been made and that the budgets to which we had been told the previous trusts were working—which Tayside Primary Care NHS Trust and Tayside University Hospitals NHS Trust now manage—were correct. However, the budgets were not underpinned by recurring income to support the level of costs that were being incurred against them. Budget managers in the organisations were working under the false premise that they had more funding available to them than was the case. Therefore, the fact that the guidance from the management executive was not available from the outset and the way in which it later appeared did not slow down the implementation of any action that we felt had to be taken.

Margaret Jamieson: You say that you were aghast when you recognised the extent of the problems. Were the accounts that were available from the previous trusts qualified or unqualified?

Mr White: The audit comments on the accounts were unqualified technically: they presented a true and fair account of what was happening in the organisations. What was not apparent was the extent to which non-recurring funding was being used to balance the books. Neither did the accounts show—the auditors would not have been expected to pick this up—the way in which new services were developed in the latter part of the financial year, the full cost consequences of which hit in 1999-2000.

Margaret Jamieson: Was no consultation or negotiation undertaken with the health board, regarding the services that were being introduced towards the year end to ensure that they were necessary or that they provided best value for the people of Tayside?

Mr White: Mr Brett may be able to answer that. I was not working in Tayside at that time, so I am not fully aware of what dialogue was entered into.

Mr Brett: In Perth and Kinross, the attitude was taken that if something needed to be done, additional staff were appointed and the health board was expected to find the funds. I felt that that attitude was totally wrong. That explains some of the difficulties that we got into.

11:15

Margaret Jamieson: That leads to the question: are the same people still running the show?

Mr Brett: They are not in chief executive positions in Tayside.

Margaret Jamieson: I hope not anywhere else in Scotland. To what extent was the absence of clear guidance from the department a problem for you in finding the appropriate solution to the financial difficulties that you faced?

Mr White: That was not a material issue. The problems that we needed to address required us to work out with clinical staff and managers sustainable solutions on the ground. The management executive was rightly looking for a way of presenting the action plan that would give it reassurance and confidence that the health system in Tayside and its managers were addressing the real issues and that they had confidence that the route map that was being set out would take us to the destination that we needed to get to.

The Convener: Are we not dealing with something beyond guidance? All the guidance in the world could not prevent bad budgeting or bad management practice. The problem for the department lies in finding a way to intervene before bad management practice produces massive deficits and problems. What powers do you have? Who is in charge?

Mr Jones: We cannot intervene in advance of the occurrence of a problem. Mechanisms must be in place to assess the relative performance of NHS management, and information must be monitored to satisfy us that all the business is

being managed appropriately. The new performance assessment framework will provide those mechanisms.

Shona Robison (North-East Scotland) (SNP): We have heard about the shock that people felt when the extent of the financial situation became apparent. People have said that they were not around at the time; but Tim Brett was around then. Paul White raised the issue of the use of non-recurring funding to balance the books. Was Tim Brett aware of the extent of that practice?

Mr Brett: Yes. Non-recurring funding had been used in a number of trusts in Tayside over a number of years.

Shona Robison: Were you comfortable with that?

Mr Brett: No; I was annoyed and angry about it. In Perth and Kinross, the problem was being disguised. We were not aware that that was how the trusts were balancing their books. I felt that external auditors should have been asked to refer to the practice if it was taking place. I am pleased to say that they have done so in the past year, but that was not the practice at the time. Year after year, meeting the three financial targets was what was required.

Shona Robison: You are telling us that you had concerns at the time. Did you not feel in a position to raise those concerns?

Mr Brett: Yes, we did. In 1998, when the scale of the Perth and Kinross problem emerged, there were detailed discussions with the existing four trusts, the incoming chief executives and finance directors of the new trusts, and the department, which led to the recovery plan of February 1999.

The Convener: We are going to deal with that issue in detail later. Keith Raffan has a question.

Mr Raffan: I want to return to a point that Mr White raised, to give Mr Jones a chance to comment. Paragraph 4.5 of the Auditor General's report comments on the reconfiguration of the trusts and their disaggregation, which was more complex in Tayside than elsewhere in Scotland. In view of that, Mr Jones, was the health department particularly sensitive to the situation in Tayside as reconfiguration there was more major than it was elsewhere?

Mr Jones: I cannot answer that, because I was not in the health department at the time. Mr Aldridge may be able to comment.

Mr Aldridge: It is true to some extent, but it worked both ways. We were very sensitive to the position in Tayside—it was the most complex of the reorganisations in Scotland. That led us, early in 1999-2000, to believe that there would be a possible period of uncertainty as the new system settled down. In retrospect, perhaps we allowed that period to go on too long before we started taking more seriously the emerging financial difficulties.

Irene McGugan (North-East Scotland) (SNP): Paragraph 6.6 of the report says that the draft recovery plan that was submitted in November 1999 identified certain savings. However, the report adds:

> "Further efficiencies depended on proposals for changes in the delivery of clinical services which could not be implemented until the Tayside Acute Services Review was completed."

At what stage was it determined that the acute services review would be cost driven? Do you accept that that was not how the situation was presented to the public at the time—in November 1999? I want to know when, why and by whom the decision was taken that the acute services review would be an integral part of making up the deficit in Tayside.

Mr Brett: I am probably best placed to answer that. When the acute services review began, we were not aware of the scale of the financial problems that we faced. You are correct to say that the remit for the review was such that it needed to be undertaken within the board's available resources for acute services.

However, it became clear during the first phase of the review that the present pattern of services in Tayside needed to change and that some of the things that needed to be done and some of the cost drivers could be considered only as part of the review. As members probably know, one of the final outcomes was that, if the review is to be implemented, it must be implemented within the allocated resources rather than the spend on acute services.

The Convener: We have adopted a structured approach so that we can deal with each topic in depth. We will return, specifically and in detail, to the issue that you have raised.

Nick Johnston (Mid Scotland and Fife) (Con): My question is for Mr Jones. You said at the start that relationships are changing; that the accounting officers used to answer to the management executive; and that accounting officers now report directly to the Parliament—presumably, they have done so since the Parliament was set up.

I do not want to stray into areas of policy, but Kilshaw does not seem to have led to any great improvement in monitoring of the accounting officers by the management executive. Do you feel that accounting officers being directly answerable to the Parliament will lead to better governance and to greater control of public money?

Mr Jones: I do not think that the change in accountable officer status has made a significant difference to governance at all. It is much more important to develop stronger relationships between the health department and NHS bodies, as well as a much more rigorous, effective control mechanism between the health department and the NHS. That mechanism is being put in place with the formation of the new NHS boards.

Nick Johnston: Why was that mechanism not put in place when the realignment of the trusts took place?

Mr Jones: I cannot answer as I was not in the health department at the time.

Nick Johnston: Is that information available?

Mr Aldridge: "Designed to Care" was published to deal with the consequences of the end of the internal market by simplifying the ways in which the different parts of the health service related to each other. It was intended that it would lead to improvements in governance and to a less competitive culture within the NHS.

Experience has shown that, although "Designed to Care" made very useful and positive improvements in how the NHS in Scotland operated, it did not go far enough. That is why "Our National Health: A plan for action, a plan for change" takes things a stage further by introducing the unified NHS boards.

The Convener: Words that I do not like to hear are, "I wasn't here." They might lead the committee to ask the person who was there. I believe that Mr Geoff Scaife was around at the time.

Mr Jones: Please do not think that I am refusing to answer the committee's questions. Mr Johnston asked me about what was happening in the health department at a time when I was not there. I am unable to say what was going on in the department then. I hope that you do not believe that I am passing the buck.

The Convener: No—it may be that we will have to direct our questions to the person who can give the answers. Margaret Jamieson has further questions, but first I invite Brian Adam to speak.

Brian Adam (North-East Scotland) (SNP): To what extent was the practice of funding deficits from non-recurring moneys prevalent? When did the department become aware of it, and what steps did it decide to take? We have heard today that it was happening in some parts of Scotland but not in others.

Mr Jones: I will pick up on the point of principle, and Mr Aldridge can pick up on some of the detail.

Whether we should use non-recurring funds as part of a financial strategy is an important issue. It is critical that every health system has a viable financial plan for a three to five-year period. We will propose that in the new finance regime. I do not think that there is anything wrong in using non-recurring funding as part of the long-term financial plan, but it is acceptable only in the context of a recurring financial solution. Part of expenditure every year is non-recurring, and there is no reason why non-recurring income should not be used to meet non-recurring expenditure.

The critical thing is to have a long-term financial plan over three to five years that demonstrates that an NHS board's plans are affordable. John Aldridge may wish to pick up on the detail.

Brian Adam: Is it not true that the use of non-recurring moneys was fairly common practice across Scotland at that time and that it was not so much a long-term plan to make things work as a short-term measure to breach the gap, to meet a whole series of deficits that were around at the time and to meet the 6 per cent target for return on capital?

Mr Jones: I think that it is right to say that, in the past, control has tended to be annual control. I strongly suggest that we need to develop longer-term plans that demonstrate the affordability of the system and to move away from the annuality that has existed in the past.

The Convener: If it is sustainable, using capital spend for revenue or using non-recurring money for revenue purposes can be all right. It is exceedingly bad budgeting practice for capital spend to be used for other purposes. That is what happened in the cases that we are discussing. How can the department prevent that happening in individual authorities? That is extremely bad budgeting and is at the heart of some of the problems that we have heard about.

Mr Jones: I agree absolutely with those sentiments. That is why, in the new finance regime, we must demonstrate that we have financially sustainable plans for each NHS board.

The Convener: You will also hope that the information that you get is accurate and does not change within three months.

Margaret Jamieson: Under the health plan, we are not to go in for the quick-fix accountancy measures that we have had in the past. You will be reviewing the accountability arrangements. Do you think that the arrangements that you are currently considering are sufficient and will deal with some of the issues that have arisen in Tayside?

Mr Jones: I think that they will be sufficient. We are developing the detailed arrangements now. They need to address all the concerns that the committee has raised this morning. It is critical that

we demonstrate that the NHS in Scotland is financially sustainable and that resources that are allocated to the NHS produce the best results for the patients who are using the service.

Margaret Jamieson: To take that a stage further, the vast majority of the discussions that we have been referring to today have been conducted in private by the department, the health boards, the health trusts and so on. To a significant extent, the public in Tayside whom you serve have been left outside, wondering what is going to happen. That compounds the difficulties that you face. In terms of the accountability review process, I think that financial management and public involvement are of equal status. Will that come through in the accountability process?

Mr Jones: Yes, it will. We say clearly in the plan that the performance management system and the record of the accountability review meeting will be made public.

Margaret Jamieson: Will they be available to the elected members for the area?

Mr Jones: Yes, indeed. They will be public documents.

Margaret Jamieson: We look forward to that new day.

I have some questions for Mr Bates in his role as the chair of the new unified board in Tayside. What do you think about the accountability arrangements that are proposed for the new set-up?

11:30

Mr Bates: I think that they will be a significant improvement. However, as has been said, the issue is to a large extent the competence of senior managers and the culture of governance that the new body establishes. The new board must be clear that it has to be transparent and open with the public and that it has to share its information. Indeed, as a member said in relation to the acute services review, we are reaping the harvest of the lack of transparency and honesty. In my experience during the past 10 or 11 weeks, the one consistent message that I have been given by staff, trade unions, members of the public, patients, councils and everyone else is, "Please tell us what is going on. We know that difficult choices have to be made."

I agree with Mr Jones that we have to strike the right balance with the critical role that the health department has to play, but that does not excuse—nor should it excuse—the new bodies from establishing high standards of governance. I am very positive about the proposals.

Margaret Jamieson: I am delighted that accountability to individuals in Tayside is high on your agenda, but you mentioned something that worries me, which is the competence of managers. In the new unified board, you will be required to ensure that high standards of stewardship are always achieved. If you have doubts—you have been in position for only 10 weeks—what action will you take to assure MSPs and the people of Tayside that you are giving it your best shot?

Mr Bates: I can assure you that I will give it my best shot. Whether that will be good enough will be a matter for others to judge. I am the fifth chairperson in five years. I intend to make, to the best of my ability, a success of the opportunity and privilege that I have been given as the new chairperson.

My answer to your question is in three parts. First, the three chairs will work as a team and will give clear signals to the chief executives and senior managers about the standards of competence that we will demand. The general public have a right to ensure that we do that. Secondly, the culture of accountability that we must establish has to be visible and transparent, so that we can re-earn some of the trust that has been lost. The three of us intend to work as a team to secure that. Thirdly, we have to apply the same degree of scrutiny, questioning and searching analysis that members of the Audit Committee have applied to probe what is going on.

I hope that this does not in any way come across as arrogance on the part of the new boy on the block—I apologise if it does—but the culture of accountability is not as visible as I intend to ensure that it will be.

The Convener: Thank you. We will check what you say against delivery.

Mr Bates: I will give it my best shot, convener.

The Convener: I am a bit concerned. In the past, when there were three boards and three sets of officials, the wool was pulled over the eyes of the boards. Now there is one unified board, but still three sets of officials. Can we guarantee that the wool will not be pulled over the eyes of those who are publicly responsible in the new unified set-up?

Mr Bates: The construction of the new unified board represents a significant change. Let me emphasise three points. First, the involvement of local authorities round the table is important to secure the partnership arrangements that we need. We have not yet touched on that issue, but a number of the solutions that we have to put in place in Tayside will require us to secure clear partnership arrangements with each of the three local authorities. Secondly, the three chief

executives and three chairpersons sit round the same table with the same agenda and the same responsibility to ensure good governance and accountability. Thirdly, the reconstruction that Mr Jones outlined put a clear duty on the new unified board to hold to account the accountable officers. It is our job to do that.

As I said, I am on a steep learning curve. I am working my way through understanding the complexities of the way in which the health service is financed—I know that I will need an immense amount of assistance to understand it. However, accountability in public around the unified board table will, I hope, give committee members the assurance that, as MSPs, they quite rightly want.

The Convener: The work of the unified board will depend on the quality of information that it receives. Will there, for example, be strong and effective local audit committees in the new system?

Mr Bates: Absolutely, yes. The role of the committees that support the new unified board—the audit committee, the governance committee and others—will be important. It is important that everything that takes place in those committees is in the public domain; it is important that people know what is going on and that what is happening is available and visible to everyone. Sometimes things have not been visible in the past, as the Auditor General's report says. That is an important piece in the jigsaw.

The Convener: Scott Barrie will ask whether poor financial control was a contributory factor in Tayside University Hospitals NHS Trust's failure to meet financial targets.

Scott Barrie (Dunfermline West) (Lab): I have a series of questions for Paul White. I refer to the final bullet point of paragraph 7.3, which mentions the monitoring processes undertaken to try to reduce the deficit. I find it somewhat strange that you did not give priority to standard budget reports that would have provided regular information on what was happening across all expenditure. Why did you employ that method and what indicated that it would be the best approach?

Mr White: I refer back to some of the comments that I made to Margaret Jamieson. It became evident early in the life of the new trust that the budgets that we had been told we had inherited were underfunded. The budgets therefore gave an incorrect impression of the funding that was available to individual managers to run their services. We were then faced with trying to find out what the right budgets should be and where cost savings could be made. We quickly set in train a process to establish where we could reduce costs and set in place benchmarking—on which the Auditor General comments—as a way of comparing costs in Tayside against those in other parts of Scotland.

Simply to have reported against the budgets that we had inherited would have falsely reassured the board that we were on target. The information systems that we put in place quickly highlighted the fact that there was a fundamental problem. The budgets themselves would not have given a reliable basis on which to track performance against targets.

Scott Barrie: Are you still employing that approach?

Mr White: No. For the financial year 2000-01, we put in place budgets throughout the organisation to deliver the whole organisation's target against the end-year position. Obviously, the final month's figures still need to be taken into account, but our tracking to the end of February shows that we have delivered the efficiency savings that we set and that our financial targets are on track to be where we agreed with the management executive that they would be by 31 March 2001.

Scott Barrie: Paragraph 6.5 of the report says that the trust has been producing recovery plans since September 1999 but that none of them has progressed as you expected them to. Why has it been difficult to identify a way out of the financial difficulties that you appear to have inherited?

Mr White: It has been difficult in part because of the complexity of the organisation. We inherited three differing systems, cultures and organisational structures. For example, we had 40 clinical directorates running principal budget holders. A process of rationalisation has reduced that number to seven clinical and one non-clinical principal budget holders.

It was difficult to get a handle on the extent to which new service developments and the expansionist policies of Tayside Health Board had triggered cost drivers. The finance staff spent the first few months in the new trust trying to understand what the cost drivers were within the overall system so that we could set budgets that were appropriate to the services that we were trying to deliver and introduce efficiency savings where they could be delivered. The benchmarking exercise was a significant factor in our targeting of the areas in which we believed costs could be reduced.

Scott Barrie: Am I right in thinking that one of the difficulties was that there was no clear scheme of delegation for budget managers? Is that one of the reasons for the reduction in their number from 40 to seven?

Mr White: That was one of the reasons. The other was that we were trying to bring together

three different organisations across Tayside. We had opportunities on the clinical as well as the financial front to build organisational arrangements within the trust that would help in the clinical delivery of services. We also wanted to bring about better financial control and better overall use of resources.

Scott Barrie: In the attempt to ensure better financial control, was there a difficulty with people not being accountable for the extra expenditure that they were incurring? If so, who was ultimately responsible for the extra expenditure that was incurred?

Mr White: Ultimately, as Mr Jones said, the chief executive of the trust is the accountable officer. I speak with the benefit of hindsight, but the evidence showed that, before we became involved with the trust, there was insufficient accountability. Developments took place on the basis of conversations between senior officers in the health board and the trust. I put in place an arrangement with Mr Brett to ensure that the only developments that could be progressed were those that were signed off by me or the director of finance. The point of that was to ensure that one of us was in a position to be certain that funding was coming into the organisation to underpin service development. That regime did not seem to exist as robustly in the past as it now does.

The Convener: For the sake of clarity, will you say whether the problems arose because of poor financial control of the on-going budget or because of the arrangement of the base budget? Is the real problem to be found in the management of budgets or in the decision making that produced the budgets?

Mr White: It is a mixture of both. In his report, the Auditor General refers to the extent to which, without an epidemiological base, Tayside is relatively over-providing in terms of services compared to the rest of Scotland. There are questions about whether too many services are being provided in the acute sector and about the method of service delivery—whether the configuration of service in Tayside is beyond what is affordable. The service base may be running ahead of the funding that is available to support it.

There is also a cultural and behavioural question about containing expenditure within set budgets. It was evident that in Tayside there was a culture in which accepting an explanation for something was deemed to be sufficient. It is not sufficient. Explaining why something is happening is the right way of diagnosing the problem, but taking action to do something about the problem is the next step that must be taken.

11:45

Scott Barrie: I acknowledge what you say about a certain culture having existed. I hope that it no longer exists to the same extent. Are you saying that people who were in charge of designated budgets were largely ignoring those budgets if they felt that they could justify to someone—presumably those in the health board—that spending was needed and that the money would come from somewhere in the future?

Mr White: It would be wrong to say that all budget managers behaved in that way, as many kept to the budgets in their spheres of responsibility. However, some service developments took place before budgetary funding was available to support them. Many of the major spend problems occurred in those pockets.

Scott Barrie: That is interesting. Paragraph 8.2 says that the trust improvement plan that you produced in June 2000 forecast the elimination of your accumulated deficit by the financial year 2005-06, but paragraph 8.5 tells us that two months later you appeared uncertain about where savings could be made. Why does financial planning in the trust remain problematic?

Mr White: Financial planning in the trust is not problematic now. Since 1999, we have had a clear handle on where the problems are. The trust implementation plan that paragraph 8.2 mentions was based largely on the information derived from the previous trusts. Before the plan could reach the trust board in June, a significant amount of work needed to go into it, in discussions with clinicians, budget holders and others. That work built up over several months. The trigger for that happened before Tayside University Hospitals NHS Trust was created on 1 April. The TIP to which paragraph 8.2 refers was based on false information and a misunderstanding or lack of understanding of the full extent of the cost pressures that were inherited.

Scott Barrie: I will return to a comment that was made earlier—I cannot remember by whom. Am I correct in understanding that one of the difficulties between the positions set out in paragraphs 8.2 and 8.5 was the integral nature of the Tayside acute services review? Is that one of the difficulties that is making planning difficult for the trust?

Mr White: Yes. It is fair to say that at the beginning of 1999 and in the latter part of 1998 the acute services review had been expected to complete—to go through its public consultation—much sooner than has transpired. Cost assumptions were built into the trust's implementation plan that presumed some changes that would flow out of the acute services review. Those changes could not be documented but, for

a range of clinical reasons and to stay within Tayside's financial envelope, it was fair and reasonable to assume that the acute services review would produce an affordable and clinically sustainable configuration or range of options. That fundamental assumption was built into the implementation plan.

The Convener: We are about to consider the inherited problems. I detect a sense of confusion here. You mentioned cost drivers, but it strikes me that cost drivers would drive services. We have heard that services were driving costs. Nobody seems to know exactly what has been going on. Was poor financial control a major contributory factor to the failure to meet financial targets?

Mr White: The financial systems that we inherited were not sufficiently robust to enable us to meet our financial targets. That became clear early in 1999 and we flagged up the issue. When I referred to cost drivers, I meant services that were incurring costs in the treatment of patients and the payment of staff wages that were not supported by recurring income to the organisation.

The Convener: I get the point about services driving costs, but I also get the impression that costs were driving services. It seems to have been a combination.

Mr White: The services must be clinically sustainable. Patient safety is paramount. The quality of patient care is an important factor. As has already been said, Tayside receives around £400 million per annum. We deliver safe, good-quality services, sufficient to meet the needs of the population, within that financial envelope. Services must be clinically driven, but they are delivered within a cash envelope.

The Convener: Are you satisfied that there are sufficient financial controls to ensure that there is no repeat of what happened?

Mr White: The trust's financial control systems are sound. The audit of last year's accounts recognises that. The fact that we are accurately tracking expenditure within the organisation is evidence that our financial systems are robust. I am pleased that we have introduced them.

The Convener: Mr Aldridge is nodding in agreement.

Mr Raffan: Mr White just said that services must be clinically driven but within cost limits; that is an ominous phrase—it sounds like health service rationing to me. The trouble with all this is that we degenerate into jargon that only the specialists and the managers understand. It is almost a way of—unintentionally, I am sure—covering matters up to the public.

Mr White: I am sorry if I gave that impression. An issue for us, as a nation, is how much of our gross domestic product we spend on health. It is for the Scottish Parliament to allocate a resource. That resource is given to health boards and to organisations such as mine to deliver services. We have a responsibility—which is largely why we are here today—to live within that resource.

Chief executives carry a number of statutory responsibilities, of which financial accountability is one. Another is responsibility for the quality of clinical care. The other chief executives and I have a responsibility to ensure that the systems that we organise to deliver services, and the quality of care that clinical staff deliver, are clinically sound and meet the best current clinical practice.

Mr Raffan: Great. However, there is another phrase that I sometimes find difficult to understand. I have got to grips over the years with efficiency savings, which means different things to different people, but what is your definition of over-provision of services?

The Convener: Two or three sentences are probably all that we require.

Mr White: The only way in which over-provision can be defined is relative to what is happening in the comparative population, whether that is Scotland, the UK or other European countries. We are talking about whether Tayside is over-providing or under-providing in certain service areas relative to the average in the rest of Scotland.

Mr Raffan: Are we talking about better services, or just more expensive ones?

Mr White: Our clinical staff and I would argue that in many services the quality of our clinical service is better than that elsewhere. The approach of the Clinical Standards Board for Scotland is to ask: what is an appropriate quality of clinical service? Lord Patel, the chairman of that board, who is employed by Tayside University Hospitals NHS Trust, speaks about setting not platinum or gold standards, but an affordable, appropriate standard, and then trying to ensure that that standard is adopted throughout Scotland as the norm rather than the exception.

Scott Barrie: I am sorry to labour this point, if you have already explained it to me. You have told us that there was a difficulty with the historic spending patterns in the health service in Tayside. Coupled with that, there was the difficulty that certain budget managers did not regard staying within budget as a priority. Has a combination of those two factors led to the seriousness of the trust's deficit?

Mr White: Yes, and the delay in implementing the acute service review has led to the continuation in the system of costs that we might not have if we were at the implementation stage of

the ASR.

Mr McAllion: If I heard you right, in an answer to Scott Barrie you said that, in certain areas, service developments occurred on the basis of a conversation between people in the health board and people in the trust. Could you expand on that? Is it right that a new development can occur on Tayside on the basis of somebody phoning somebody else up, without the matter going before a board or the chief executive sanctioning it?

Mr White: That would not happen now.

Mr McAllion: Did it happen?

Mr White: Yes; it happened.

Mr McAllion: Can you give us an example?

Mr White: Yes. In Perth, around £300,000 was spent to recruit additional nursing staff. The then director of nursing services believed that she had an understanding with the then planning director of Tayside Health Board that funding would follow an agreement that they reached to recruit the extra nursing staff. That funding did not follow. Moreover, there is no record in either the health board or—that we could find—in the trust to support the contention that there was to be a funding transfer from the health board to the trust to support that recruitment.

Mr McAllion: So the trust committed itself to spending £300,000 and employed a number of nurses without the trust board or the health board knowing anything about it?

Mr White: I am getting into a matter on which I do not have the exact details. I hesitate to say that I was not there.

Mr McAllion: It seems that nobody was there. Everybody who was there when the key decisions were taken has gone missing.

Mr Brett: I will help Paul White by saying that there was no acknowledgement of that at the health board. I can confirm that what Paul said was the case.

Mr McAllion: It beggars belief that the health board, which is charged with the responsibility for the health service across Tayside, did not know that one of its trusts was spending £300,000 to take on nurses. I cannot believe that any management system that allows that kind of thing to happen could be supported for a minute. People should be sacked for that.

Mr Brett: I remind members that the culture at that time was of self-governing trusts, which had autonomy and responsibility for providing services locally. Therefore, the information that one might have expected to be passing between the trusts and the health board was not doing so at that time.

Mr McAllion: Even within the trusts, somebody should have had to sanction the recruitment.

Mr Brett: I mentioned that I was very concerned when I became aware of what Paul White has described. The culture was that we must appoint more nurses, perhaps on safety grounds or for other reasons, and that the board would find the money.

The Convener: Perth and Kinross has been named. Did the same thing happen in either of the other two trusts?

Mr Brett: In Dundee, there were issues around the pace at which new cancer services were developed and came on stream. There had been an agreement with the trust that we wanted the development of cancer services but again, if my memory serves me rightly, I had cause to express concern to Paul White at an early stage that, in appointing additional staff, the trust was going quicker than the resources that were available would allow.

Shona Robison: Once it became apparent to those in charge, whoever they were, that decisions had been made that should not have been made, was the matter addressed with the people who had made the decisions?

Mr White: Those people are no longer in Tayside. They were not employed by the trust when I took over on 1 April 1999.

Shona Robison: Were they never tackled about making those decisions outwith their competence?

Mr White: I cannot answer for what happened at the time when they were taken on. That was under the previous trust.

The Convener: I know that les absents ont toujours tort. It is just a pity that those people are not here to be answerable. Perhaps that is what we should be looking at.

12:00

Margaret Jamieson: At the end of the day, Mr Jones, you are responsible. I appreciate that you were not in post at the time of the previous reorganisation. We have heard a lot about the self-governing culture that was prevalent, but it is quite clear that there were individuals who took decisions that they were not allowed to do within their competence or their level of delegated powers. Can you assure us that those individuals are no longer in the employ of the NHS in Scotland? If they are, what action will you, as chief executive of the NHS in Scotland, take?

Mr Jones: I do not know who the individuals are. Obviously, I need more details about the issue that we have just heard about. What I can say very clearly is that the principle of committing

expenditure without having a funding source is quite unacceptable. The whole point of bringing all the chief executives into the same NHS board with corporate responsibility for the total resource is to stop such things occurring again. It is quite unacceptable management behaviour.

Margaret Jamieson: Although I accept that you say that it will never happen again, the situation in Tayside is allegedly the fault, not of anyone at this table, but of individuals who have gone to other airts and pairts. Surely it is incumbent on you to ensure that those individuals, some of whom are referred to in the Auditor General's report, are not replicating what they have left in Tayside in other parts of Scotland. I hope that they have not gone to Ayrshire—I am looking out for my own area.

Mr Jones: It would be absolutely unacceptable for that behaviour to be replicated anywhere in the NHS.

The Convener: If you do not have that information, Mr Jones, there are people sitting beside you who do. Will you be pursuing those matters?

Mr Jones: Yes, indeed.

Nick Johnston: Has any disciplinary action on those matters been taken against any of the individuals in the previous trusts?

Mr Brett: I am not aware that any disciplinary action has been taken.

Nick Johnston: Would you expect to be aware of any action that was taken?

Mr Brett: Yes.

Nick Johnston: So I think that we can assume that no disciplinary action has been taken.

Mr Brett: Concerns were drawn to the attention of the finance director then, before Mr Aldridge was in place, but I do not know what action was taken.

The Convener: What kind of message does that give to officials, and what kind of system are we running if that can happen?

Mr Bates: May I respond to that as I have done before? It is important to put on record to MSPs some points that have perhaps not been explained. I emphasise that I do this with a degree of hesitation, as it is based on talking to people, reading documents and looking at what I think has gone on. My view, for what it is worth to the Audit Committee, is that Mr McAllion put his finger on one of the key issues: organisations were pulling apart instead of pulling together, and they did not communicate and were secretive in a way that was not helpful. As Mr Jones said, the sort of accountability in governance that would have meant that senior management executives understood quite clearly that they did not have that authority was absent.

I hope that members do not mind my balancing that view by reminding them that we are talking about a very small number of people. The nurses, doctors, dentists, physiotherapists and all the other members of staff were delivering, and continue to deliver, high-quality patient care services. However, my assessment is that the key factor, which Mr McAllion was driving towards, and which the new arrangements will substantially address, is that organisations were pulling apart rather than pulling together.

The Convener: It may have been a small number of people, but a large amount of damage was caused. I am bothered by the fact that there were investigations and reports, yet no action was taken. Can we be assured that what happened will not happen again?

Mr Bates: As the new chair, I will answer. First, as I hope members will accept, I reserve my position until I examine the whole organisation and all current senior individuals. I am not in a position to comment one way or another on current or past individual employees, and I would not want to give that impression. I am looking critically at the issue, and I want to discuss it with Mr Jones and others. I assure the committee that the three chairs who will lead the new unified board are determined to establish a culture of accountability that will be part of the process of continuing the changes that have started.

The Convener: I would like to hear of a similar commitment at national level, Mr Jones.

Mr Jones: I support everything that Mr Bates said, and suggest that it may be useful to the committee if we prepare a joint note on actions against individuals. Obviously, more investigation is required. We can come back to the committee.

The Convener: That would be helpful.

Mr Lloyd Quinan (West of Scotland) (SNP): My question was on the same point and, up to a point, it has been answered by Mr Jones. However, surely the responsibility extends from here. I accept what Margaret Jamieson said. I hope that none of the individuals involved now works in the Argyll and Clyde Health Board area. Given that they are no longer in post, surely they will have requested references. Therefore, it is incumbent on us to carry out a full inquiry to make sure that references have not been given to those people, and that they are not creating mayhem elsewhere in the health service, either in this country or elsewhere. Can we have an assurance on that from Mr Jones?

Mr Bates: I apologise to the Audit Committee. I am not aware of any references that have been

written for any individuals who were in the critical roles at the time. I associate myself with Mr Jones's comment that it would be appropriate for the two of us to come back to you with a note.

However, I make the point that we are also talking about the way in which boards related to one another. That is a factor that has not been laid on the table, and it is the reason why I have emphasised that the three chairs of the acute trust, the primary trust and the new unified board have given a clear signal to the chief executives and others that we are singing from the same hymn sheet. We are not interested in people running with separate agendas. They all work for, and will be held visibly accountable to, a single NHS family. Equally, we will have to make some difficult choices. We are spending money that we do not have and we will have to explain to the public why we make the choices that we do. I certainly expect the senior managers to deliver them.

The Convener: We shall return to these issues. The real nub of the issue is not past recrimination, but future progress.

I will take a question from Keith Raffan, before one from the very patient Paul Martin.

Mr Raffan: Can I go one step further? You say that you will produce a joint note. That is all very well and I am sure that it will be helpful to the committee in relation to Tayside, but the important point—Mr Jones may be able to confirm that he has taken this on board—is that we need a uniform disciplinary and accountability procedure throughout Scotland, and not just in Tayside. As Mr Bates said, the situation has gone wrong here because of a few people and they should be disciplined, but that situation reflects on those who give good quality service. We want to ensure that the same thing does not happen again, and that there is accountability in every health board area.

Mr Jones: I agree entirely. Everything that we have said about the new accountability arrangements applies to the whole of Scotland. The arrangements have to be tighter and sharper, and they will be.

The Convener: This will be the last section before lunch. Questions will be asked by the very patient Paul Martin. We have stomped round your territory a bit, but would you like to address the problems inherited from the former trusts, and the reasons for the deficit?

Paul Martin (Glasgow Springburn) (Lab): My first question is for Mr White. In paragraph 29 of the report, the Auditor General recognises that many of the financial problems were brought about as a result of reorganisation. How many of those difficulties still have an impact on financial performance?

Mr White: We are still living with the consequences of some of the decisions that were taken. They have become part of the recovery plan, and it will take us time to get over the problems that we got into. To that extent, the difficulties are still present, but one could not attribute them to reorganisation per se, as that is some two years behind us now. However, we are still living with the consequences of decisions about services that were taken in the lead-up to reorganisation.

Paul Martin: Can you be more specific? What sort of issues are you talking about?

Mr White: For example, there have been difficulties with the development of cancer services. I am not saying that those services are not good or that they are not needed, but the way in which those service developments would be funded was not clear at the time. Would something else not happen? Would something that was happening be halted or changed in such a way that resources would be freed up for reinvestment? Those difficult decisions were not taken. The legacy that has been left arose from a mixture of decisions that were taken and decisions that were not.

Paul Martin: My next question is for Mr Brett. Would you confirm for the record that you were the chief executive of Dundee Teaching Hospitals NHS Trust until December 1997?

Mr Brett: Yes, I was.

Paul Martin: I refer you to paragraph 7.3 of the Auditor General's report, which says:

"The Taskforce identified six examples of a lack of financial control".

Do you accept that there were control weaknesses in the trust?

Mr Brett: Dundee Teaching Hospitals NHS Trust was about two thirds of the size of the new Tayside University Hospitals NHS Trust. As Paul White indicated, during each of the four or five years when I was chief executive, we managed to achieve our financial targets. I accept that, when the new and much larger trust was created, Paul and his new team needed to review arrangements and make changes. However, at the time, I was satisfied that we had effective controls and that those controls allowed us to deliver our targets.

Paul Martin: That is a straight contradiction of the point made in the report. I am asking whether, during your time as chief executive—that is, before Mr White's time—there were examples of a lack of financial control. Yes or no would be an appropriate answer.

Mr Brett: No. There were problems with individual services, as there always are, but

arrangements were made to cover those problems from other areas of the trust's activities.

Paul Martin: Do you disagree with Mr Bates, who made the point that the Auditor General's report is fair, accurate and measured?

Mr Brett: No, I do not disagree with that statement.

Paul Martin: How can you possibly not disagree with the statement that the Auditor General's report was measured, accurate and fair in many ways, while, at the same time, you believe that you had effective financial control measures in place?

Mr Brett: You are going back to the time when I was responsible for the previous trust, which was more than three and a half years ago.

Paul Martin: So you do not disagree with the Auditor General's report.

Mr Brett: I do not disagree with that paragraph, because I think that it concerns a particular situation that occurred around 1998 and into 1999, which was after I left Dundee Teaching Hospitals NHS Trust.

Paul Martin: Can you comment on what happened during the period that followed your secondment?

Mr Brett: On—

Paul Martin: Would you comment on the period that followed your elevation to the health board?

Mr Brett: In what sense? Are you asking me to comment on what I perceived the previous trust's controls to be?

Paul Martin: Yes.

Mr Brett: I have already indicated that I was disturbed and concerned—in fact, I was annoyed—by what I discovered had been happening in Perth and Kinross. There were also pressures in Dundee and Angus during 1998-99, as we approached the establishment of the new trust. However, they were pressures that I was familiar with: pressures in renal medicine and cancer medicine. From experience, I knew that the new trust would find ways of dealing with those pressures. With hindsight, it is apparent that many factors came together and there was an accumulation of problems in all the previous trusts.

12:15

Paul Martin: I refer you to paragraph 7.3 of the report. We are told that the outgoing Dundee Teaching Hospitals NHS Trust recruited some 200 staff in the final months of its existence, thereby contributing to more than £2 million in deficit, which was inherited by the new Tayside University Hospitals NHS Trust. What do you think of the action that was taken by the former trust?

Mr Brett: Paul White and I will give you a joint answer. I was concerned about that action. It is my understanding that the trust had vacancies in a number of key areas during that year, for which it was unable to recruit. As Mr White has said, budget holders proceeded to fill them in the latter quarter of that year in the mistaken belief that there was funding for them. There was a serious problem in the fact that the senior management of the trust was not aware of the fact that filling those posts would exacerbate the problems that Mr White inherited the following year.

Mr White: There is not much that I can add to that. With hindsight, it was clear that the funds that were originally allocated for those posts were being used in other ways—the funding that was freed up by those vacancies was being used to underpin other areas of expenditure, which were not curtailed or stopped to allow the recruitment of those staff.

Margaret Jamieson: We are talking about who was where in the organisation. Forgive me, but is the present director of nursing not the same individual who was in that post before reorganisation?

Mr White: She is, but she is not responsible for the direct management of nursing staff. She is the professional head of nursing staff, but in Dundee Teaching Hospitals NHS Trust she was not responsible for the budgetary management of nursing staff. There is no way in which she can be held to account for that.

I would like to clarify, for the record, that the director of nursing who was referred to in an earlier response is not the current director of nursing. Also, the director who was referred to earlier was the director of nursing in Perth and Kinross Healthcare NHS Trust rather than Dundee Teaching Hospitals NHS Trust.

The Convener: Thank you for that clarification.

Shona Robison: We have heard about Perth and Kinross Healthcare NHS Trust and Dundee Teaching Hospitals NHS Trust. Can you tell us what the situation was in Angus NHS Trust, in terms of its financial management systems?

Until Tim Brett spoke, I thought that everyone acknowledged that there had been a long-term culture of a lack of financial control, to the extent that people were making decisions outwith their competence. However, what Tim Brett said has confused me, and we are beginning to get mixed messages. Can you clarify what you are saying, Mr Brett? Do you accept everything that was said before you spoke, and that there was a long-term culture in Tayside of a lack of financial control?

You seemed not to accept that that was the case. I am now confused about whether you accept it or not.

Mr Brett: No, I do not accept it. The difficulty is in determining the period that we are talking about and the period that the Auditor General has examined. In the four previous trusts, the financial targets were met. It has subsequently become apparent that, over the past year or two of their existence, a number of them—notably Perth and Kinross Healthcare NHS Trust—managed to meet their targets by using non-recurring funds. I am not saying that there were problems in all four trusts; however, when Paul White and his team came in, they rightly had to bring together three separate systems and address all the other problems of reorganisation, including people's uncertainty about what jobs they would have. There was a need to recast that situation, which they have done.

The Convener: The previous trusts could balance their books by bad budgeting practice. It strikes me that that option was inherited by the new trusts. It was therefore inherited by many of the officials who worked for the previous trusts, who were involved in the decision making that led to reorganisation. There has been significant continuity in those who make the decisions.

We are talking about the present trusts and the finance and culture of the former Dundee trusts. Sir William Stewart, a former chairman of Dundee Teaching Hospitals NHS Trust, became the chairman of Tayside Health Board; you were the chief executive of the former Dundee Teaching Hospitals NHS Trust and you became the chief executive of the health board; Mr Wells also came from Dundee Teaching Hospitals NHS Trust. Many of the officials are the same. There was continuity of decision making at the top level, with accountable officers, and the problems that they inherited resulted from decisions that they took part in earlier. However, you are saying that you are not responsible for the situation. Can you clarify your position?

Mr Brett: First, I agree totally with what Mr Jones has said. If non-recurring funding is being used, that must be on the basis of an agreed longer-term plan. There is clear evidence that that was not the case in certain situations in Tayside.

Sir William Stewart did not become the chairman of the health board, but the new chairmen of the trusts joined the health board—that was another change that "Designed to Care" introduced. There have been considerable changes in senior personnel in Tayside over the past three years. Three chief executives and three finance directors from the previous trusts are no longer in Tayside.

The Convener: I refer you to pages 3 to 4 of the report, which underline the task force's findings:

"Lack of effective financial control"

and various budgeting procedures that are totally unacceptable, such as

"Absence of corporate working and governance … Lack of effective communication … Overprovision of services".

On page 29, we are told that the deficit was £11.1 million and that £1.7 million was given by Tayside Health Board to balance the situation that was created in Perth and Kinross Healthcare NHS Trust. Nobody can be blamed for the impact of changes in capital charges, but that still leaves about £10.9 million-worth of management decisions for which the present managers and accountable officers are responsible. Matters were inherited by many of the same people who now hold office. Who is in charge? Who is responsible?

Mr Brett: An answer has already been given to that question. The chief executives of the previous trusts were responsible and the new chief executives and I have been responsible over the past two years. The items that are listed on page 29 of the report were, as the Auditor General correctly states, factors that the new trusts inherited. The primary care trust also inherited some factors. Because Mr White brought in a new team, it inevitably took time for those factors to become apparent.

Mr Bates: This is clearly a matter of great concern to the Audit Committee, and rightly so. First, I state clearly on record that there is no question whatsoever but that there are significant lessons to be learned about past practice. Secondly, it was in 1995-96 that Tayside Health Board's auditors reported serious concerns, which led to the Kilshaw inquiry and its findings, thereby indicating—as the Auditor General has rightly said—that the problems are deep-rooted. As the newly appointed chairman of the unified health board, I do not want the Audit Committee to be in any doubt about that.

I come from a local government culture that may not be considered appropriate to this debate. However, in that culture, if virement is used to transfer unspent money under one heading to another, it has to be done openly and transparently and those who are responsible are scrutinised and held to account. I want to explain clearly to Ms Robison that, without doubt, the Auditor General's report is fair, measured and accurate. We have many lessons to learn from past practice.

The Convener: A number of members want to come in at this point. With their permission, I have one further question for Mr Brett. I refer him to the heading on page 29 of the Auditor General's report:

"Under achievement of cash releasing efficiency savings."

Mr Brett was partly responsible for that underachievement. He asked for cash-saving measures to save £3 million, but a saving of only £2 million was produced, so £1 million was added to the deficit. He seems to be saying that that is not his problem. I would like to hear some responsibility being taken for those decisions. Many of the same people who were part of that decision-making process have continued in post.

Clearly, problems were built into the system. One problem, which comes straight back to Mr Brett, was the unrealistic setting of cash-releasing efficiency saving targets that added £1 million to a deficit. Did you take part in that decision-making process, Mr Brett?

Mr Brett: Yes. At the end of 1998, we became aware of the scale and size of the problem that existed in Perth. In conjunction with the former trust and the new trust's officers, we prepared a financial recovery plan, which has been referred to. The plan was agreed jointly by the three chief executives at the end of March in that year, which was the beginning of the new financial year. The board made arrangements to fund both trusts for the recurring problem that existed in Perth and Kinross. However, that left a significant efficiency saving target for both trusts to achieve.

That was the basis of a decision that it was not unusual to make at that time in the NHS. It is something that we have asked both trusts to undertake again this year. The weakness and the problem that I would put my hand up to is that, at that point, our measures were not as effective as they should have been in holding the trust to account for the achievement of that target. Last year and this year, we are much more precise and clear about where savings will come from and we check jointly that they are achieved.

Nick Johnston: I hope that Mr Brett will forgive me for saying that his evidence leads me to believe that he has a prejudice against Perth and Kinross. The Auditor General points out that it was Dundee Teaching Hospitals NHS Trust that hired the 200 nurses. I ask Mr Brett to confirm two things. First, if you had still been chief executive, would you have hired those nurses? Secondly, what controls that you had in place were relaxed to allow the trust to hire those nurses?

Mr Brett: First, I will answer Mr Johnston's second point. At that time, the health board did not have any direct managerial responsibility for ensuring that the trusts achieved their financial targets. We received no information on detailed staffing issues in the way that he has described. The health board therefore had no knowledge that that was taking place. In the hypothetical situation that I had been in the trust then, I hope that I would have been aware that holding off on those vacancies would contribute to meeting our financial targets in that year. I would have stepped in, either to stop the posts being filled or at least to have agreed with my colleagues ways for funds to be provided to achieve that.

Nick Johnston: Mr Brett has misunderstood the second part of my question. What controls that were available to you at Dundee Teaching Hospitals NHS Trust were removed to allow the trust to hire the 200 nurses?

Mr Brett: I am not trying to be difficult, as I was not there at the time. There was a gap of 15 months—

Nick Johnston: Yes, but you must have had controls to have stopped nurses being hired in previous years. What were the controls and how were they removed?

Mr Brett: The controls were that each of the group directorates that we had in place at that time had a staffing budget and received regular reporting information. The human resources department would not have been allowed to process the filling of posts unless it was clear that funding was available for them.

Nick Johnston: Are you saying that Mr Waldner, who I believe was your successor, removed those controls and allowed the nurses to be hired?

Mr Brett: I cannot answer that question, as I do not know whether that is the case. However, if I go back to an answer that I gave previously, it is my understanding that, in a number of cases, directorates were unable to recruit. They were then able to do so in the latter part of the year, when they believed that they had funds to cover those posts.

12:30

Brian Adam: Mr Brett, I was intrigued that, when you were asked where the source of the problem was, you chose to highlight the hiring of nurses in Perth and Kinross at a cost of £300,000. I presume that that is the cost of between 15 and 20 nurses. Why did you highlight that figure rather than the 200 nurses and other staff who were hired without any authority in Dundee?

Mr Brett: I chose that example because I was aware that, as Mr White indicated, there was a disagreement between the then director of planning at the health board—for which I had responsibility at that time—and the director of nursing in the trust.

Brian Adam: Does that mean that there was no disagreement about the additional staff that were

employed in Dundee?

Mr Brett: The health board was not asked about that and was not involved in that decision.

Brian Adam: My next question is not solely for Mr Brett. Will you give me an idea of whether the University of Dundee was involved in some of the decisions that were made. I note that one of the areas where there was unfunded growth was in cancer services. The University of Dundee has excellent facilities for undertaking research in that area. Was the relationship between the university and the various health bodies in any way involved in causing those additional cost pressures?

Mr Brett: I will begin to answer that question although I suspect that Mr White, too, might like to comment. There is a close relationship between the University of Dundee medical school and the NHS. That needs to be so, as many of the staff work jointly for the two bodies. There is a great deal of collaborative work between them. The Ninewells hospital site is a quarter owned by the University of Dundee and there are some shared services on that site. It is vital that good joint planning arrangements are in place to deal with the sort of issue that Mr Adam has highlighted.

Some years ago, discussions took place between the university, which—as members know—has excellent cancer research laboratory and scientific facilities, and the trust about the need to develop clinical cancer services. When I was at the trust, Dundee Teaching Hospitals NHS Trust, the University of Dundee and the health board agreed on the appointment of additional professorial posts. The difficulties occurred when the individuals who were appointed disagreed about the pace of development of clinical services.

Brian Adam: Perhaps we can now hear from the Scottish Executive health department as to whether the creation of additional professorial posts, not only in Dundee but elsewhere in Scotland, has led to unfunded growth in services.

Mr Jones: It is fair to say that there are additional financial pressures in any of the teaching board areas due to the type of research and development work that goes on there. That is not a reason for not having strong financial plans for the introduction of new services. It should probably encourage teaching board areas to have stronger plans to manage the introduction of new developments in their areas. It is not acceptable to allow new developments to grow in an area without that growth being planned and funded properly.

Brian Adam: Will Mr Bates comment on the relationship between all the heath bodies and the University of Dundee? How will that be managed in future, particularly given the likely developments and pressures for developments?

Mr Bates: I will comment with some hesitation and apprehension because I am not as knowledgeable as I would like to be to answer that question properly. It is proper to preface my answer with that note of caution. I have had fruitful discussions with the university. I have also had important discussions with some of our neighbouring health partners, because that is an important part of looking to the future.

We want to retain our standards of excellence and cutting-edge research in Tayside, but as Mr Jones says, that must be married to the reality of the financial envelope in which we live. We can do that through close dialogue with the key players in the university and our neighbouring health authorities. I assure the committee that Professor McGoldrick and I have embarked on those discussions. However, as Mr Jones says, accountability rests in ensuring that expenditure that cannot be properly identified is not committed to funding developments.

Brian Adam: Where there is a centre of not only national, but international excellence—as there is for oncology in Dundee—does the department not have a duty to allow the consequential clinical and service developments to be recognised and funded nationally, rather than merely as part of the envelope of finance that is available to Tayside?

Mr Jones: The additional cost of research and development is funded separately. It is not necessarily equitable for services in teaching board areas to develop faster or to a higher level than those for the Scottish population generally. The cost of the service content, rather than the research content, must be assessed against all the priorities. It would be wrong for teaching hospital services to develop faster than mental health services, for example, or for services in Edinburgh to develop faster than services in Fife, simply because Edinburgh has a medical school.

Brian Adam: It is difficult to separate the research and development function from the service function. If you are to continue to develop research and development, there will be consequential effects on services.

Mr Jones: We must address that issue when we think about specialist services, which tend to radiate out of the teaching centres. In the health plan, we have said that we will address how we fund specialist services around Scotland as part of the new finance regime. As Peter Bates said, it is critical to get all the partners and all the health boards that could use specialist services to agree on how the services should be funded in a planned way. That is part of the new finance regime that will be introduced for the next financial year.

The Convener: Before I pass to Lloyd Quinan, I

should say that two trends disturb me. While budgeted services were cut, unbudgeted services increased. Mr Brett said that Tayside Health Board did not receive information from the trusts. Can we be assured that such management practice will not continue?

Mr Bates: On your second point, I can tell you categorically that there is now a group that brings together the three chief executives and their directors of finance to monitor spend against budget from month to month, and a group that brings together the three chairs and the chief executives and which has recently commenced meeting every fortnight. Financial performance will be critical to that budget, and it will have a high profile.

Mr Jones: From the department's perspective, five clear points emerge from this morning's discussion. The first is the need to show that we have strong and effective financial management across a health board area. Secondly, as Peter Bates said, we need to get all chairmen and chief executives to manage the total health resource in that area and achieve the best mix of services from the resources that are available.

Thirdly, we must have sustainable financial plans to demonstrate that health strategies are affordable in an area—I mean annual rather than long-term plans. Fourthly, we require an accountability and performance management system that allows us to demonstrate that what I have described is happening. Finally, the health department must have a stronger performance management function. I am working on all five points as part of our plans to put the new health boards in place by 30 September.

Mr Raffan: One of Mr Jones's answers slightly concerns me. It is inevitable that there will need to be more service development in the teaching hospitals than elsewhere. You mentioned Fife. In the region that I represent, there are three health board areas, two of which do not have teaching hospitals. As a result, Fife looks towards Ninewells and Tayside. When specialist services are being developed in one place, it is important that all other areas have access to those services instead of there being an equal division of funding between a health board without a teaching hospital and one that does, such as Tayside.

Mr Jones: I did not say that teaching hospitals should cost the same as standard district general hospitals. My point was that we cannot have unplanned developments radiating out of teaching hospitals; we cannot disadvantage populations that are served by district general hospitals in favour of populations that are served by teaching hospitals. We require a planning mechanism that allows health boards to sign up for a national or regional strategy for specialist services.

Mr Raffan: I am grateful for that clarification. However, the crucial point is that the teaching hospitals serve not just their areas but other areas. Ninewells hospital is important for Fife.

Mr White: I want to add a supplementary comment to the discussion between Mr Jones and Mr Raffan. It is right that Ninewells provides largely DGH-type services to north-east Fife, but the area also avails of tertiary services. The relations between Tayside and Fife—and particularly between our trusts and Fife—have developed very well over the past year to 18 months. For example, clinical networks have been developed, most notably in ear, nose and throat services. Clinicians from Tayside provide services in Victoria hospital in Kirkcaldy and likewise ENT surgeons from that hospital take sessions at Ninewells; they have a truly joint service with joint appointments of consultant posts. In that way, a non-teaching health board such as Fife can have very close and good access to specialist skills. Those services do not have to be delivered at Ninewells but can be delivered on an outreach basis.

Mr McAllion: We have heard that in the final quarter of 1998-99 Dundee Teaching Hospitals NHS Trust recruited 200 nurses and other staff at a cost of £2.1 million without having enough money to do so. In February 1999—in that very same quarter—Tayside Health Board submitted a financial framework to the management executive, suggesting that there were no financial problems. That framework was drawn up with the co-operation of the outgoing and incoming trusts, which means that everyone must have met to discuss it. Are you saying that no one at any of those meetings mentioned the recruitment policy in Dundee and Perth and Kinross or the use of non-recurring moneys and unfunded developments? When all those trusts met to discuss their financial position, did no one mention what was happening then in Tayside?

Mr Brett: I will quickly run through what happened. As is normal practice, the director of finance contacted his colleagues in the four trusts in November of the previous year and invited them to enter into the preparation of the following year's budgets. As part of that process, they were all asked to identify cost pressures and other areas of financial concern. We were very much aware of the issues in Perth and Kinross, but we were also aware that there were issues in Dundee and in Angus. Those issues were pulled together. My memory is that we were aware of the Perth and Kinross staffing issue, because that had happened the previous year. I do not recall being aware of the Dundee situation, but the finance director of the trust had every opportunity to put whatever he wanted on the table so that we were aware of it.

12:45

Mr McAllion: Were any minutes taken at those meetings?

Mr Brett: Yes.

Mr McAllion: So there is a record of what was discussed?

Mr Brett: Yes. There is a record of the meetings and there is also the financial plan that was submitted.

Mr McAllion: If those records are available, they should have been made available to the Audit Committee. If major problems such as this are occurring in the health service, it is quite significant that all the managers from all the trusts should come together to discuss the next year's budget without mentioning some of the most serious problems facing the health service in Tayside.

Mr Brett: I do not recall what happened, but it would be fairly easy to go back and check whether that was the case.

The Convener: Can you make those minutes available to the committee?

Mr Brett: Yes.

Margaret Jamieson: Mr Brett has brought Angus into the equation by saying that there were problems there, but we have not heard any evidence this morning about those problems. Can you tell us about them?

Mr Brett: The problems in Angus were not on the same scale as the problems in Perth and Kinross and in Dundee. My understanding is that the Angus problems related more to the loss of the income that the trust had received from Grampian Health Board for the use of certain long-stay beds, particularly at Sunnyside royal hospital, now that Grampian Health Board was making less use of them.

Margaret Jamieson: Do you have a figure for the problems to which you refer?

Mr Brett: I will give you a figure in a moment, as I think that I have that information with me.

Mr White: The figure for the Tayside University Hospitals NHS Trust aspect of that was about £500,000.

Irene McGugan: I have another question for Mr Brett. Did Dundee Teaching Hospitals NHS Trust, of which you were chief executive until December 1997, ever take out large loans that now have to be repaid?

Mr Brett: No—not in that sense. Because of the new developments, particularly the transfer of services from Dundee royal infirmary to Ninewells hospital, the capital stock at Ninewells has increased. More recently, in the past 18 months, the capital charges that the trust pays have increased, particularly in relation to the new build at King's Cross hospital.

Irene McGugan: Would you expand on that a little? What impact did that have, and is that still having, on the financial situation in Tayside?

Mr Brett: I am not sure that I can give you the detailed figures. From memory, the new building cost £20 million to £25 million. As the Auditor General's report says, the NHS has to pay interest on those new developments. There is an element of interest and an element of depreciation. That is laid down as part of the financial regime. Those charges ensure that buildings and equipment are used fully and properly. The capital stock in Tayside is worth some £300 million, nearly two thirds of which is in Tayside University Hospitals NHS Trust and just over a third of which is in Tayside Primary Care NHS Trust. Both trusts, like all other trusts in Scotland, pay capital charges on those amounts.

Mr White: In Tayside University Hospitals NHS Trust, capital charges, covering the buildings and equipment that we use to provide services, account for about £22 million a year.

Irene McGugan: Are all those figures and that procedure clearly known about by auditors and everyone involved in making up plans for the future?

Mr Brett: Absolutely. Those figures would have been taken into account as part of the development and agreement of the new capital developments that are taking place. They would be a key part of the financial plan for any such development.

Mr White: I would like to clarify that a revaluation of the estate in Tayside took effect from 1 April 1999. The revaluation figures were not known until they were confirmed in June or July 1999. As is indicated on page 28 of the Auditor General's report, additional capital charges were made because of the increased value that the estate was deemed to have.

Kate MacLean: I have a question for Tim Brett. Like the answers that have been given to some other questions, Tim Brett's answer to Paul Martin's second question is puzzling.

Tim Brett said that he was chief executive of Dundee Teaching Hospitals NHS Trust until December 1997. Are you confident that there were no control weaknesses in financial management prior to December 1997 that contributed in any way to the current financial difficulties of the health services in Tayside?

Mr Brett: I am confident because each year our external auditor commented on those issues. Each

year, there were pressures and problems, some of which came through into the problems that we have discussed this morning.

Kate MacLean: Balancing the books is one thing, but financial mismanagement is another. Were there no practices that I would classify as financial mismanagement in Dundee Teaching Hospitals NHS Trust, such as the use of capital receipts to prop up revenue expenditure? Were there no such financial practices that contributed to the current financial difficulties?

Mr Brett: In 1998-99, after I had left the trust, Dundee Teaching Hospitals NHS Trust sought—and, I believe obtained—approval to use non-recurring funds to help with the bridging costs of moving from Dundee royal infirmary to Ninewells.

Margaret Jamieson: I am becoming confused. You indicate that you were totally satisfied with the procedures that were in place when you moved from the trust to Tayside Health Board and that everybody had clear accounts signed off by the auditors. However, we have heard that the audit reports were not robust and did not tell us the true extent of what was happening. How does that tally with the statement that you have made to Kate MacLean?

Mr Brett: The previous comment was in respect of the Kilshaw report's findings, which were highlighted by the Auditor General. Following that, as Mr Jones has said, the interim chief executive and then I took strenuous efforts to revamp, revise and update the health board's corporate governance arrangements. Those arrangements were commented on by external auditors. Those reports are available and indicate that significant progress was made by the board in addressing those issues.

Nick Johnston: Paragraph 8.9 of the Auditor General's report says:

"Staff numbers in TUHT are 250 below their April 2000 levels."

Is that another example of your holding back recruitment of staff to meet financial targets, Mr White? Can you give a breakdown of where those 250 staff are—Angus, Perth and Kinross or Dundee—and what grades and posts they are? I do not expect a breakdown now.

Mr White: I can give you a breakdown, but not at the moment. We have adopted a different process, which was referred to earlier in respect of Dundee Teaching Hospitals NHS Trust. Rather than simply holding posts vacant and using that funding to support other areas of expenditure, we have made fundamental changes to service delivery patterns so that staff who were employed to deliver services in the way in which those services were originally configured are now no longer required. There has been a change in how wards are configured and services are designed that allows us to continue to provide those services safely, to appropriate quality standards and to the right volumes, but to do so more efficiently. The staff reductions have come about through sustainable changes in how we organise services.

Nick Johnston: I take it that you can provide the committee with the information for which I asked.

Mr White: On where the posts are?

Nick Johnston: And on the grades.

Mr White: Yes.

The Convener: Paul Martin wishes to speak, but the Auditor General would like to intervene at this point, so I call Mr Black, to be followed by Paul Martin.

Mr Robert Black (Auditor General for Scotland): A number of comments have been offered in the course of the last couple of hours about the proper role of audit and about the extent to which audit engaged in the various issues that have been mentioned.

To assist the committee, I will quickly run through the three issues that have been raised in the course of the morning. Early on, reference was made to qualified or unqualified accounts. The issue of the certificate on the accounts and the signing of that certificate is simply a matter of looking at the numbers on the face of the accounts against accounting and auditing standards. It is simply a question of saying that the numbers are properly presented.

In a sense, it would be inappropriate to conclude that a clean certificate by itself means that all is well in a body that has been audited. That is why the code of audit practice, under which all auditors whom I appoint must operate, goes much wider than simply providing a certificate on the accounts, and provides a report to local management on governance, financial stewardship and issues concerning performance, so far as that is appropriate.

The second issue is the role of audit in relation to governance. The committee has been informed this morning—quite rightly—that the auditor appointed in the case of Tayside Health Board started expressing concerns at a very early stage. Those concerns were drawn to the attention of the department—or the management executive, as it then was—as they emerged. In later years, the auditor commented favourably on the improvements that were taking place in the governance arrangements of the health board, and also said that further work needed to be done. In other words, it was a matter of work in progress

rather than a problem solved.

The third point on which I wish to advise the committee relates to the auditor's responsibility to identify something as fundamental as the use of non-recurring funding. I emphasise that it is not the role of audit to take over the role of management. Mr Jones said that it might occasionally be appropriate to use non-recurring funding if management were confident that it had a long-term, sustainable solution. That means that non-recurring funding is probably being used to smooth over a short-term period of inadequate financial resources to reach a stable state. That is entirely appropriate. It is not the role of auditors to look forward and second-guess management on the policy issue of where managers will find the required resources.

In my previous role as Controller of Audit, I produced an overview of the health service in Scotland each year. In my overview report on the 1997-98 accounts, I referred in one paragraph to concern voiced by a number of auditors that the 1998-99 financial targets could be difficult to meet in a number of bodies because of the use of non-recurring funding in 1997-98. We provided an early indication to NHS management that that issue should be examined. I repeat, however, that it is not the role of the auditor to pass a judgment on that; we simply provided an indication to the health service that we thought that there was an issue in that regard. I think that that was right and proper.

The Convener: And it is the role of managers to manage.

Paul Martin is signalling to me that his points have now been covered, and there appear to be no further questions.

We have had a fair session. Lunch time now approaches, so we can all rest a little. I advise members of the public who are intending to come back for the afternoon part of the meeting that they must retain their tickets. Anyone not intending to return should hand over their ticket to the main reception desk, which will allow others to take their places. That also applies to the public in the overspill room. Members of the public will be allowed back into the building from 1.45 pm, for a 2 pm start.

I thank everybody who has participated so far.

12:59

Meeting adjourned.

14:00

On resuming—

The Convener: I reconvene the meeting. I remind everybody to turn off all mobile phones and pagers—the bane of modern existence.

This afternoon, we will consider the elimination of the deficit, the acute services review and the unit cost of health care in Tayside, as well as leadership, governance and communication in Tayside health bodies. I ask members of the committee to stick to that programme as tightly as possible.

I call on Lloyd Quinan to start us off this afternoon and to examine whether there is a clear picture of how and when financial balance will be achieved and financial deficits eliminated in Tayside health bodies.

Mr Quinan: I refer Mr White to paragraph 8.6 of the Auditor General's report, which makes it clear that the results of the acute services review are an essential component of achieving financial balance and eliminating the trust's financial deficit. Can you explain how you expect the review's results to impact on the trust's financial performance?

Mr White: In Tayside, there is a patently unaffordable configuration of services and level of service provision. That has been demonstrated clearly by the excess costs that have been incurred over the past two years. The acute services review takes place against that background. The brief that has been set for that review by the health board is to produce a set of clinically sustainable and financially affordable options.

The acute services review reported to the health board at the end of last year. The health board is leading a process to prepare a consultation document, which will go out to public consultation in May for the statutory period. Following that, the health board will make decisions in conjunction with the trusts about which range of options can be recommended to the Minister for Health and Community Care for implementation.

Mr Quinan: I accept that, but I asked what you expect the impact of the review to be on the trust's financial performance.

Mr White: I believe that out of the review will come a series of recommendations for significant change in clinical services, which will allow Tayside health bodies collectively to reprofile the way in which services are set across Tayside. Looking round the country, I would cite Lothian Health as being some way ahead of many other health boards in Scotland in having reviewed its acute services. Lothian Health is considering a

different blend of services between the acute trust, the university hospitals trust and the primary care trust and, of course, the significant change that will come with the new royal infirmary. That is an example of the type of major service change of which Tayside is just on the threshold.

Mr Quinan: I understand that. I refer you to the last sentence of paragraph 8.6 of the Auditor General's report, which says:

"Until the findings of the Review are finalised and the impact of any changes to the delivery of acute health care is quantified, it will not be clear when TUHT will be able to eliminate its accumulated financial deficit."

Do you have any comments on that sentence?

Mr White: One of the features of Tayside is the extent to which services are duplicated or triplicated. In today's world of medicine, and with the population base in Tayside, there is not a case for that duplication and triplication of services. That issue has been addressed in the acute services review and has, understandably, raised much concern among the public. There has been much public reaction to the issues that have been discussed in different forums in the past 18 months. I find it difficult to think of any other health area in Scotland that provides for a similar population to Tayside and has the extent of duplication and, in some cases, triplication of services that exists in Tayside.

Mr Quinan: Has that duplication or triplication contributed heavily to the deficit situation you find yourselves in?

Mr White: It is a significant factor. The way in which services are configured makes them more expensive to run.

Mr Quinan: That suggests that, in effect, the health board's policy is being controlled or dictated by the financial deficit. Is that correct?

Mr White: I can understand why that perception exists, but Tayside has a responsibility, which we take seriously, to get back into financial balance. We need to find a way of configuring the services that we provide in Tayside—in terms of geography and quantity—that will fit within the funding that we have. That is different from saying that cost is driving the service. It is perhaps a moot point. The review, which I am sure we will come to, was heavily populated by clinical staff from Tayside University Hospitals NHS Trust and Tayside Primary Care NHS Trust. All the sub-committees were jointly chaired by a GP and a consultant. To that extent, the options that have been derived are heavily clinically led.

Mr Quinan: So how do you expect the results of the acute services review to impact on the trust's financial performance?

Mr White: They will help us to get back into balance. For full implementation of the acute services review, in terms of the development proposals that are contained within it—for example, a new-style hospital in Angus—we will need to have a balanced financial position. That will enable us to progress to that new way of delivering health care for the population base.

Mr Quinan: Thank you.

My next question is for Mr Jones. Paragraph 7.14 of the Auditor General's report tells us that, as a result of comments made by the task force about the monitoring arrangements, you advised the Minister for Health and Community Care that your department would take a greater role in performance-managing the Tayside situation. What form has that greater role taken? More important, especially for the public, what benefits have been achieved by that intervention?

Mr Jones: We stood down the task force around Christmas. Since then, I have been meeting the chief executives in Tayside regularly to review progress in addressing the deficit and implementing the recovery plan. Before that, the first phase of the recovery plan was successfully implemented, with more than £6 million being saved in the first year of recovery. There are now plans for a further £6 million to be recovered in the current financial year—2001-02. We have much closer involvement in that recovery plan.

Mr Quinan: How will the acute services review impact on the trust's financial performance?

Mr Jones: What is important is that the NHS in Tayside's plans for all its services are within the resources that are available to it. We need to consider all service provision and the best distribution of the total pot against the whole of Tayside's service provision. There must be debate around the amount to be spent on primary care and consideration of the impact that investing in primary care will have on the need for acute services.

Paul White mentioned Lothian Health's acute services strategy. Its plan was to invest heavily in primary and community services, which would reduce the need for hospital-based services; the service that would be achieved would be more accessible to the general public and not based on the institutions as much as would be the case under traditional plans. That would allow reconfiguration of the acute services.

I want consideration of the integrated service rather than a specific examination of acute services in isolation.

Mr Quinan: My final question is for Mr Brett.

Paragraphs 8.7 and 8.8 of the Auditor General's report start with the fairly encouraging news that the trusts are on target to achieve planned savings

in 2000-01, but go on to highlight emerging difficulties. Can you explain what those difficulties are and, more important, how you intend to deal with that emerging situation?

Mr Brett: Yes. My understanding is that the committee—following its meeting in Glasgow with senior managers—will be familiar with the situation. During the past 12 months, several additional external pressures have come to light, which have changed the situation that we faced last summer. Some of those pressures are listed in paragraph 8.8. The additional cost of junior doctors' hours is likely to amount, in this year alone, to an extra £2.5 million in Tayside. That figure will double over the next couple of years if we cannot rearrange rotas. Another pressure is the European working time directive. Such external pressures amount to about an additional £7 million.

This year, we—the three of us, with our finance directors—took the target figure that we had agreed and through our joint management forum, which I suspect we will discuss later, developed a plan for next year. The health board signed off that plan at its March meeting. The plan involves both trusts in producing detailed proposals for cost savings, which went to the respective boards or committees last week and will come back to the board in two weeks' time, so there is a further round of detailed efficiencies. We have already given thought to how we will tackle the final year in 12 months' time.

Mr Quinan: You must have been aware of the European working time directive, yet you suggested that it was an unforeseen circumstance. Would not it have been possible to plan for the directive?

Mr Brett: Both trusts advised us what the cost would be, but the directive is one of the matters that this year's settlement must cover. That was one of the givens that we—along with all other health systems in Scotland—received. We have taken it into account, but—to return to Mr White's point—that is made more difficult by the number of sites that we have. For example, it is necessary to provide on-call teams, so the more sites that are covered, the more the problem is exacerbated.

Mr Quinan: But you were aware that the European working time directive was coming into force?

Mr Brett: Yes.

Mr Quinan: Barring, or rather excluding, your ability to close down those sites and sack staff, you must have been able to project, on the correct numbers, what the cost of the working time directive would be to the trust.

Mr Brett: Yes. We have done that. The cost has been factored into this year's financial plan. All health systems in Scotland are facing that issue.

Mr Raffan: You mentioned two significant pressures—the European working time regulations and junior hospital doctors' pay—but there are others. There are clinical pressures, for example the hepatitis C epidemic that Scotland faces and the cost of combination therapy treatment, which is £7,000 to £9,000 per person. I ask about that to seek an assurance—as far as you can give one—that there will be no treatment rationing to meet the stringent financial saving plans.

Mr Brett: Last year, we reached agreement to develop an approach for the introduction of new treatments and therapies based on advice that we would be given by the area drugs and therapeutics committee. The hepatitis C issue is current and will need to come back to the board through the joint management forum. The costs of treatment for hepatitis C are considerable, as I am sure you know, and we will need to decide what priority we give to that. Some treatment has been provided in the past, but if we are to provide new treatment, we will need to establish where the funds will come from rather than, as might have happened previously, just going ahead and providing the treatment.

14:15

Mr Raffan: We talk about efficiency savings, but the real issue is defining them. We have had so many efficiency savings, over the years, that they are no longer savings in administration, but clinical savings.

Mr Brett: Yes. I shall elaborate on what Mr White has said and Mr Wells may want to comment. There are many different ways in which services can be delivered. You will be familiar with the way in which many treatments can be administered on a day-case basis, for example. There is still much scope for that. One of the other issues that we face in Tayside is delayed discharge. We have 270 patients in Tayside hospitals whose clinical condition means that they do not need to be there. That is a major problem for us to work on with our colleagues in the local authorities. If we could make a significant impact on that, that would go a long way in alleviating the financial pressures on both trusts.

Mr Raffan: I accept your point about the over-provision of services. As a regional member, I would be concerned if, to meet financial targets, we went in the opposite direction and there was under-provision compared with other health board areas.

Mr Brett: Clearly, we would not wish that either. Through our joint forum and the new, unified health board, everybody should see the whole

picture—be it of primary or secondary care or whatever. Those are not easy decisions to make.

Irene McGugan: On the acute services review, Mr White said that there must be financial balance to achieve new health plans and health provision in Angus. Given that there has been no financial balance for some years, and no real guarantee that we are even close to that, and given that today we have heard of further reductions in services at Stracathro hospital in Angus, is it possible that, purely because of continuing funding difficulties, Angus will have little or no acute provision even before the outcome of the acute services review?

Mr Brett: Huge amounts of acute provision are delivered in Angus and will continue to be delivered there. For many years, a comprehensive range of clinicians and specialists has been based either locally or at Ninewells hospital and there is no suggestion that that will change. It is proposed that there will be a new hospital that will concentrate on rapid diagnosis and straightforward treatments that can be administered on what is called a day-and-stay basis.

A couple of options will come out of the acute services review, concerning whether the services will be concentrated in one centre or dispersed throughout the existing community hospital network. That is the choice. We cannot afford to continue with the present pattern of services.

Irene McGugan: Is it not the case that, according to the figures that we have, we cannot afford the new proposal either? Given that reductions are taking place in the provision of services in Angus, will not the people of Angus, in the short to medium term, be left with a reduction in what was available previously and no prospect of new, improved, long-term provision? No one here can say when the deficit will be eliminated and when the financial balance will be sufficient to allow investment of £20 million in any new provision in Angus. In the short to medium term, will not the people of Angus be left with little or nothing—or at least with a reduction, not an improvement, in services?

Mr Brett: First, what appeared in the local press this morning is an issue that is not driven by finance. It has been raised with us by senior physicians who are expressing concern over the continuing safety of the health service in Angus. The board will consider that issue in two weeks' time, but it is not being driven by finance. Over the past two or three years, we have done our best to try to sustain the Angus service until the acute services review has been completed. The advice that we have received, over the past few weeks, is that clinical staff are worried about the situation and believe that, on the grounds of safety and best modern practice, acute emergency patients in Angus would be best looked after at Ninewells hospital.

Secondly, the future provision of services in Angus is dependent on our getting back into balance. We have plans to do that over the next two years. We also have an understanding that, subject to public consultation, capital funds will be provided for a new hospital in Angus. I would like that to be provided within five years. I hope that we can proceed quickly with the detailed planning of that in conjunction with both trusts. The siting of that facility would be a matter for discussion with the people of Angus.

The Convener: We are straying well away from the issue.

Mr McAllion: Let us return to the emergency situation that is described in paragraph 8.8 of the report. You mentioned that health bodies in Tayside have identified an additional £19.2 million and additional commitments of £9.7 million, which gives a total of £28.9 million of new expenditure. Is that unfunded at the moment?

Mr Brett: The £18 million to £19 million in additional funds that the board has received this year will go a long way to meeting that.

Mr McAllion: You have received £18.7 million, but you have identified £28.9 million in potential expenditure. That leaves a deficit of £10.2 million. It seems as though a new deficit is emerging.

Mr Brett: That is being addressed in the detailed plans that we have agreed with both trusts for efficiency savings in the current year.

Mr McAllion: So, the gap of £10.2 million will be met by more local cuts?

Mr Brett: It will be met by more efficiencies, yes.

Mr McAllion: Is that in addition to the cuts that are described in paragraph 8.3 of the report? Efficiency savings were set at £6.8 million last year, £10.8 million this year and £14.8 million next year. Are the cuts that you mention additional to those figures?

Mr Brett: Yes, they are additional to those figures. Some of the savings that were made last year will roll over and contribute to this year's figure.

Mr McAllion: So, in total, what kind of cuts are we talking about in Tayside over the next three years?

Mr Brett: I invite Mr White and Mr Wells to provide some details of our current proposals.

Mr White: I shall indicate some of the additional cost pressures. The fuel tax levy will add about £750,000 to costs within Tayside University Hospitals NHS Trust in this financial year. There

are other issues such as junior doctors' hours and the intensity payments for consultants, which have been mentioned. There are additional costs of around £350,000 in the current year for maintaining maternity services at Perth. Pressures are also identified in a range of clinical services because of the increase in patient numbers—I do not mean new services being developed but, for example, new patients being identified who would benefit from renal dialysis. As those patients begin treatment programmes, there is a cost pressure in renal services of around £400,000 in the coming year. Those are all recurring costs.

Mr McAllion: I am trying to get a handle on the kind of figure that we are talking about regarding cuts in the health service locally in Tayside over the next three years. Those figures are greater than the figures that are presented in paragraph 8.3 of the report.

Mr White: The figures in paragraph 8.3 are about addressing the inherited deficit. In addition, like every trust in the country, we are facing other cost pressures that arise year on year.

There are two ways in which the NHS, in Scotland and in the UK, deals with such cost pressures. The first is through additional funding—Mr Jones made reference to the 5.5 per cent uplift that Tayside received in the current financial year. In addition, every health care system is expected to change the way in which it provides services and to make those services more efficient year on year, in order to release resources for meeting some of those other cost pressures.

Mr McAllion: If you add up the figures in paragraph 8.3, they come to more than £30 million of cuts. If you then add the deficit of about £10 million that is outlined in paragraph 8.8, we are talking about £40 million being cut from the health service locally. Is that what we are talking about?

Mr White: No, I do not think that the figures are as dramatic as that.

Mr McAllion: In that case, can you explain the figures to me? That is the figure that I get by adding up all the figures in the report.

Mr White: We touched on the inherited deficit, which is the extent to which the trusts in Tayside are spending over their allocation. The other cost pressures, some of which are identified in paragraph 8.8, are in-year cost pressures that are common throughout the health service. Clinical staff flag up some of those cost pressures. For example, they might say that a new drug is coming or that a new type of treatment is available or has been approved for use. Each local health care system must then make a choice about how it prioritises those treatments.

Mr McAllion: Can you tell me what efficiency savings you will be trying to achieve over the next three years across the health service in Tayside? How much is involved?

Mr White: I can speak only for the Tayside University Hospitals NHS Trust. Between now and achieving financial balance in two years' time, we are probably looking to try to reduce costs by, or make efficiency savings of, about £14 million to £16 million.

The Convener: But you will need to go beyond that amount.

Mr White: I am sorry—

The Convener: You will have to go beyond £14 million to £16 million, as there will be other burdens.

Mr White: In part, the total is dependent on the financial settlement for the health service in the financial year 2002-03, which is not yet clear. For example, it depends on the amount of new money that comes into the health care system and on which there will be cost pressures—some of which have yet to be identified—in 2002-03. We must find ways of managing those cost pressures to stay within our overall resource.

Mr Brett: I want to try to clarify the figures in paragraph 8.3 for Mr McAllion. The savings figure of £6.8 million rises to £10.8 million, which rises to £14.8 million. That is not an accumulator—you should not add the figures together. The figures are for savings of an additional £4 million and then another £4 million.

Mr McAllion: I am just trying to get at the global figure; it would be helpful if someone could give me that figure.

The Convener: I hear words such as reconfiguration and readjustments, but the reality is that there is a deficit, plus another accumulated deficit to take care of, plus the massive new burdens that the trust is facing. In response to that, we are hearing proposals for cost savings and efficiencies. How efficient will your organisation have to become to cope with all those proposals? Does not it mean that there will be cutbacks and closures of services, rather than efficiencies? I would like to get at what the witnesses mean when they use those words.

Mr White: In a descending hierarchy, the approach that we have adopted is to consider the efficiency of the service at one level, effectiveness, duplication and volume of services before we get anywhere near the quality of care. We are looking to preserve safety and quality of care. It is a truism that applies to any part of the health service: the more expensive the systems for delivering health care, the less actual health care can be delivered via those systems. We are trying to make our systems as efficient as possible, so that the

maximum amount of funding goes into direct patient care.

Mr Bates: I will try to give a straightforward explanation. It is absolutely right to say that there are three parts to the process. First, over a period of three years, the NHS in Tayside is expected to get its budget into balance. There was a plan in place to achieve a target figure in year 1, and that figure was achieved. Plans are in place to achieve year 2 targets, and year 3 will involve further savings to balance the budget. Convener, you are absolutely right. To be clear, for the record, the discussions that we are having with our colleagues in the health department are extremely supportive and helpful. It is important to convey that point. I am having, as are my colleague chairs, many discussions with Mr Jones and other colleagues about managing years 2 and 3.

14:30

The second point is, assuming at the end of year 3 or thereabouts that the budget is back in balance, you are right that sitting in the books will be an accumulated deficit. The Auditor General has referred to that. My priority, which is the right priority, is to balance the budget. We will then have to face, after another two years, further discussion with our colleagues in the health department about the accumulated deficit.

The third point is service redesign. It is important to get that on the record. I appreciate the concerns that members have raised, but simply because things have always been done in one particular way does not mean that they can or should continue to be done in that way for ever. Huge changes are taking place in the health service in the development of expertise. While I must be extremely sensitive to public concern, and will be, at the end of the day, we cannot continue to do everything that we are doing at the moment in the same way. That is the reason we are sitting in front of you this afternoon and why we find ourselves in this position.

As I said in my opening comments, and as the Auditor General said in his report, we have to get on with the job of making the changes. If some of the decisions that should have been taken five, four and three years ago were taken then, we would not be in the position we are in now. We have to get the budget in balance, then we have to discuss the accumulated deficit with our colleagues in the health department, but at the same time, to achieve the changes, we are going to have to make significant decisions.

There will be consequences of those decisions, and we will have to live with them, otherwise not only will the budget not balance, but we will continue to spend money that should be being spent more wisely on those groups in the community who do not have a voice and cannot shout loudest—for example, people whose inequality drives up their ill health, people with mental illness and learning difficulties, and frail and vulnerable older people. We need to ensure that their needs are addressed, otherwise we will lose the game. I am determined that that is not acceptable, so we have to make some very difficult decisions.

The Convener: It is not just about the way that things are done. People are concerned that things are done and continue to be done. Can the joint chief executives get together and provide a letter listing all the cost pressures that are anticipated for 2001-02 and 2002-03? Could you indicate the likely efficiency targets?

Mr Tony Wells (Tayside Primary Care NHS Trust): For the financial year that just passed last week, Tayside Primary Care NHS Trust had a savings target of £2.4 million. We have a high level of confidence that we will achieve that target. We also had a £2 million repayment of end-year flexibility from the previous year's problems with generic drugs, which has been repaid. We are confident that the primary care trust will be in balance for the past financial year. We have a target for this financial year of £2.9 million, which is part of the figure that you just heard. We have plans in place to address that figure in-year.

I consider service redesign to be an important part of the recovery agenda. The primary care trust is working in partnership with the acute trust on a number of service redesign initiatives. Medicine does not stand still. It is important that we look at patients' journeys through the system and make them as efficient as possible, so that they receive the best service that they can expect from us in Tayside.

The Convener: Can you assure us that your budget will be balanced without the use of one-off resources, because I believe that last year it was one-off resources that allowed you to balance the budget?

Mr Wells: We were allowed end-year flexibility with the agreement of the health department. It is considered to be good accounting practice for the health service in Scotland to meet one-off costs from the increased price of generic drugs. That was a UK-wide in-year problem for one year. We looked at one-off capital receipts to repay that overspend on drugs in that year. Our auditors and the health department were satisfied with that treatment.

Shona Robison: My question is directed to Mr Jones. We have heard over the last few minutes about the extent of the deficit. Paul White said that there were a number of measures to go through to

clear the deficit, such as the avoidance of the duplication of services and service redesign. At the bottom of that hierarchy was the quality of patient care, which, it was indicated, would be the last thing to be affected by the efficiency savings.

In response to questions about that, the Minister for Health and Community Care has consistently said that the quality of patient care will not be affected by the situation in Tayside. After what Mr Jones has heard over the past few minutes, can he give us that assurance today?

Mr Jones: The minister and the health department are absolutely clear that addressing the deficit must not affect the quality of patient care. Yes, I can give that assurance.

Shona Robison: Are you saying that, if everything else has been gone through but further savings are required and we come to the bottom of the hierarchy that Paul White described, the health department will not allow the quality of patient care to be affected?

Mr Jones: We will not have the quality of patient care compromised. That does not mean to say that we will provide additional funds. It is a matter of addressing the problem differently.

Shona Robison: If everything else has been done to address that problem, what other response can there be? If all other options have been taken, what other possible action could be taken?

Mr Jones: Allow me to take a step backwards. We fund the NHS based on an amount per head of population. That is weighted to reflect issues connected with rurality and to reflect health need. Every health board in Scotland receives the same amount per head of population, subject to that weighting. At the end of the financial year 2000-01, nine of the 15 health board areas are managing within their resources and six are running deficits. Three of those deficits are less than 1 per cent—they are almost in balance. It would be difficult to argue that, if Tayside is receiving a fair share of the national resource and well over half of Scotland is living and providing services within that resource, Tayside would not be able to provide services of a safe clinical quality in that funding formula.

I do not believe that the scenario that you are describing is correct. The critical thing is for the health system in Tayside to examine how it uses its fair share of the national resource to provide the right balance of services. All those services must be clinically safe. It is not acceptable to compromise safety in addressing the problem.

The Convener: Can you clarify something that bothers me? We appear to have high-level services in Tayside that the area cannot afford. I think that we are being told that there are low-level services that the area cannot afford. When you say that you want top-quality services to be available to people, everybody agrees, but what you are missing is the location of those services. It appears that there must be a level of services appropriate to an area that may not be supplied to that area; it may be centralised. We have noticed that services beyond this area were supplied, which you cannot afford, and we notice that fundamental services now have to be shifted and people have to travel to them. Where does that take us? That situation is not driven by service but by finance and past decisions.

Mr Jones: When we consider how to plan health services, we have to strike a balance between three factors. We have to consider access to services, clinical safety—we talked about that in connection with some of the Angus health services earlier—and cost. We spent the morning talking about how to ensure that there is proper financial management in the system. Health care planning is about balancing those three factors. My point is that, if we are funding health boards based on a fair share of national resource for their population, the only way that we could allow one health board to spend more than its fair share would be to reduce the fair share of another board area. That is the issue that has to be addressed.

The Convener: If there is an area for which the report says there is an over-provision of services, that must attract funds, which would be taken away from other services that would otherwise be allowed to go ahead. There may be a fundamental imbalance that has to be addressed.

Mr Bates: The fundamental imbalance is exactly the issue that I was referring to. Choices need to be made and investment needs to go into expanding our primary care services. If we do not get ourselves into a position to do that, we will continue to suck money into sustaining things as they are now for ever.

I am concerned about issues surrounding locality, distance and travel. However, competing needs have to be balanced and we have to consider our ability to react to modern medicine as it develops and our capacity to generate as many quality and clinically safe services as we can to as many of the Tayside population as we can. That means that we have to make choices. The Auditor General has said in his report—absolutely rightly in my judgment—that we have to get on with that and that we should have been doing so over the past two or three years.

Paul Martin: Will Mr White clarify that, as a result of cost efficiency savings, there will not be any increase in waiting times?

Mr White: That is one of the other targets that the trust has to meet. As at the end of March just finished, we are on target for our waiting times and waiting lists. We have plans in place for delivering on our component of the national waiting list target for March 2002. I confirm that that is one of our targets.

Paul Martin: Can you guarantee the people of Tayside that, as a result of cost efficiency savings, they need have no concerns that waiting times may increase?

Mr White: I can guarantee that, short of anything exceptional happening, such as a consultant going off ill. I can assure you that we have plans in place to deliver on our waiting list target and to maintain waiting times. We have had no chartered guarantee breaches in the trust since last summer.

Paul Martin: So it would not be as a result of cost efficiency savings if there were to be an increase in waiting times.

Mr White: No, it would not. We have built into the plans for the cost reduction programme for this year capacity to allow us to deliver on our waiting list targets.

Mr Raffan: Paul Martin has covered the major point that I wanted to raise. Obviously, lengthening waiting times would compromise quality of patient care. The waiting time is an integral part of the quality of care. It is a complex issue and I am grateful for the reassurance that Mr White has given.

Earlier, Mr Jones said that more than 50 per cent of health boards are meeting their budget. That means that 40 per cent are not. As usual, the glass is half-full or half-empty. However, 40 per cent is a large and considerable minority by any standards.

Mr Jones: I said that three of the six that were likely not to be in balance on 31 March just passed have a deficit of less than 1 per cent. That is as close to balance as you are going to get. Getting within 1 per cent of budget is good performance. The latest forecast for the NHS in Scotland is within 0.2 per cent of balance. I think that that is a success story.

Mr White: I would like to add something to the answer to Mr Martin's question about waiting lists. One area that could frustrate us in achieving waiting list targets is the degree of delayed discharges—having elective operating and bed capacity blocked out, in effect, by patients who are awaiting discharge. As Mr Bates said earlier, we have set in train a series of discussions with the local authorities to address that matter. However, it is slightly outside our direct control.

14:45

Brian Adam: I am not too sure that we have received a clear-cut answer on the question of the accumulated deficit and its role or otherwise as a driver in the acute services review. The final year of the three-year recovery plan, 2002-03, requires a further saving of £4 million. We are told that in paragraph 8.5 of the report. We are also told that a notional over-provision for Tayside in terms of the costs—if that is the appropriate phrase—also happens to be £4 million. We have been told that there is duplication and triplication of services. The implication is that some services have been provided unnecessarily and most inefficiently.

Given that, is it true that the acute services review is totally driven by a need to achieve a financial balance—given that the two figures that I mentioned are identical and that we are being told today that we have over-provision in the form of duplication and triplication of services?

Mr Brett: I will at least begin to answer that. We have a higher level of spend on acute services; I am not sure if you wish to return to that in a minute. We can tell you about some of the things that we are doing to address that. It is partly explained by the fact that we are delivering services on three sites in Tayside, for a population of 390,000. The acute services review will address that. The recommendations that are coming forward will also help us address that, and will lead to some savings.

However, as Mr Bates has said, we also need to invest further in primary and community care, so that there is less need for patients to travel, and so that more care can be delivered locally. We began that process last year. If members wish to know more, Tony Wells can give you much information on what we are doing. They are innovative, exciting things, and are helping to support patients at home, to support their relatives, to keep them out of hospital, to get them home sooner and to provide one-stop clinics. We are taking a range of positive, exciting actions. We believe that they will allow us to reduce expenditure on acute secondary services.

Brian Adam: But can I get a straightforward yes-or-no answer to my question: is the acute services review driven by the need to deliver the £4 million—which is apparently the excess for Tayside—to achieve the final year's balance, which also just happens to be £4 million?

Mr Bates: May I answer that question in a straightforward way, convener? Mr Jones rightly said that cost is a factor that must be borne in mind—so must quality of care, and so must accessibility. When the acute services review process started, the agenda in Tayside, as it was understood, was quite different to the one that we

are discussing now. It is worth reminding ourselves that the original intention was to create headroom at the top of the acute services pyramid to invest in primary care services.

I have absolutely no doubt—and I have consistently said this to all the community groups, patients groups and elected members to whom I have spoken, whether in councils or in the Parliament—that we have to take cost into account as we consider options from the acute services review. Cost is not the only factor, but will be a factor. It would be absolute madness to sit here and tell you that we will be making decisions and choices without thinking carefully about cost and consequence. We have to balance three very difficult things at the same time that we are recovering a deficit. That is the management challenge that we and the chief executives have to deliver on. Cost is certainly a factor, but is not the only factor.

Brian Adam: In that case, the purpose of the acute services review, or rather its direction, has been subverted in order to address the matter of the financial deficit.

Mr Bates: My answer to that is no, I do not think that it has been subverted. The review has probably concentrated minds in a different way. That is a fair way of putting it. If there were no acute services review, I am sure that the three chief executives would conduct an acute services review by another name, because we are considering decisions that needed to be taken—several a long time ago. It would be unfair to say that the review has been subverted by the deficit. The review will concentrate the minds of top managers on ensuring that they reach the financial figures on balance but drive the new agenda of change.

The Convener: Are you saying that the acute services review has not been pre-empted by cost savings?

Mr Bates: I do not think that anything has been pre-empted.

The Convener: What about today's announcement on Stracathro?

Mr Bates: Today's announcement was not really an announcement. Mr Brett honestly shared with the committee the fact that concerns that we must take seriously have been drawn to the attention of the trust's chief executive. The reason why we are here is that we are spending more money than we have on the books to spend. Regardless of whether we had an acute services review or anything else, we would have had to make choices about how we spent that money.

Margaret Jamieson: I will pick up on something that Mr Brett said. I was somewhat astounded by his comment. The service in Tayside seems to evolve for the sake of evolving, and whether it is being delivered in the right way and at the right level is never considered. It is as if Tayside had suddenly been dragged kicking and screaming into an acute services review, when most other health bodies in Scotland have been involved in such processes for a great many years. We now find that Tayside has a financial deficit. I am astounded that you are the only common denominator and that you can make such a statement.

Mr Brett: I apologise if I misled you. Is it appropriate for me to go into some of the background of the acute services review?

The Convener: Yes, if you do so succinctly. We are about to ask questions on the acute services review, but you can respond immediately to the point.

Mr Brett: Clinical staff have been hugely involved in the acute services review and have bought into it, and the public have been engaged with it for the past two years. That has been done in a conscious and measured way. If I gave you any other impression, I apologise.

Margaret Jamieson: Much in medicine will change in two years. Something changes almost every day. You do not show me that an in-built natural process has operated in Tayside and that you have considered the nuts and bolts of every service as someone has asked for it to be developed, reduced or redesigned. You do not seem to have considered the impact of such changes or whether what you are trying to do is making the best use of the money that is available. You say that you have done that only in the past two years.

Mr Brett: No, I have been here for a considerable time, during which the process has continued.

Margaret Jamieson: Perhaps the process has not been as robust.

Mr Brett: As part of the acute services review, all our acute services have been scrutinised by groups of clinicians from primary and secondary care. I am satisfied that they have considered all the options for delivering the services in the future.

The Convener: I do not think that the process was as smooth as that from the consumer's point of view. Nick Johnston will discuss the acute services review process.

Nick Johnston: From the evidence that we have heard, we can be in no doubt that the acute services review is integral to Tayside's financial health. Exhibit 7 on page 20 of the Auditor General's report shows the progress stages for the Tayside acute services review. All the witnesses

must be aware that the perception in Tayside is that the review has been not clinically driven, but financially driven, and centred on moving services into Ninewells in Dundee.

Bearing in mind the figures that are not included in the Auditor General's report which show the inequities in funding across Tayside, why has the review taken so long? What lessons can the rest of the health service learn from the three and a half years of misery that patients and staff have been put through? Finally, when will we see the finished report of acute services in Tayside?

Mr Brett: I regret that the process has taken so long. It has taken about two years to date. Although there was discussion about the review in 1998, it did not get under way until April and May 1999. After an intensive period during 1999, a phase 1 report was produced at the end of the year, which I and some others thought would allow us to move quickly on to public consultation. The report made out the case for change and listed a number of possible options; however, it was soon apparent at the end of the year that there had been no detailed work-up of the options and that, critically, the clinical groups in Tayside had not bought into the detail of the options, particularly in relation to the implications for primary care.

That first phase was led by Professor Roland Jung, who is a senior physician at Ninewells; we consciously decided that phase 2 should be led by another clinician. In fact, it was led by two clinicians—Professor David Rowley and Dr Andrew Russell, who is a general practitioner—because we wanted to ensure that it was clinically led. That phase should have been completed by last December; however, the task force felt that we should spend more time, particularly in ensuring that the costings of the options were robust. We undertook that work, and the report was presented at a special meeting of the board in January this year.

While it prepared the consultation document, the board decided that it wished to take a little more time to have further discussion with some of the interest groups, which is what we have been doing over the past eight to 10 weeks. A joint consultation paper from the three chief executives will come back to a board meeting in two weeks' time, and I expect that, as Paul White said, we will move to consultation during May, June and July. The board will then have a special meeting at the end of August to consider the comments with any recommendations being sent to the minister.

Nick Johnston: Perhaps Mr Jones can tell us when we can expect the report to emerge from the department.

Mr Jones: It is difficult to put a fixed time scale on that until we see the document. However, I would be disappointed if we could not turn a document around within two months.

The Convener: Perhaps the length of time was exacerbated by the big uncosted options that were paraded before the public. Why were the options not costed right from the very start? At least then during the initial consultations—which seem to have happened a long time ago—people would have known what was before them and something could have been implemented. Parading big uncosted options at public meetings has helped nobody and is partly why the process has lasted so long.

Mr Brett: I readily acknowledge that we have learned many lessons as the process has gone on. From the word go, we were very keen to inform the public about what we were doing. We have had a total of three rounds of meetings across Tayside over this period. Furthermore, we have set up patient reference forums and have engaged consultants to help us get the public's views and play them into the process.

We used the first round of meetings to explain the review and why it was needed. At the start, I certainly thought that there would be more detailed options at the end of phase 1. That was not the case, and we had to spend time ensuring that the options were properly worked up, that the implications were fully appreciated and that primary care—the other key people who will deliver the review's recommendations—were on-side, happy and understood the proposals.

The Convener: The words "lack of clear strategy" come to mind.

Nick Johnston: Mr Bates, you are a fresh face in this situation and have already said that you want openness and transparency. You will be aware of the depth of feeling across Tayside on this issue. How will you develop the matter to ensure that the groups involved feel that they are involved and that they have contributed to the process?

Mr Bates: I am aware that much of the strength of feeling is from people who—understandably—passionately want and vehemently argue for services to be retained in their present form. While that should be understood and respected, it must be balanced against the agenda that we have spent the past few hours discussing. It is my intention to ensure that the 90-day consultation period is open, transparent and real and is carried out as imaginatively as possible. However, we must also be very honest with people throughout Tayside about what we can and cannot afford and about what the real choices are.

I would not want to miss the opportunity today to try to convey, in a way that we have not done thus far, that there are many groups in our community

whose voices are not articulated to the same extent as those of other groups. There is a huge agenda of need that we have to balance carefully. I am under no illusions—it will take more than 90 days to re-earn the patience and trust of the wider Tayside community. It will take us years to do that, but 90 days is the start of that process.

15:00

Nick Johnston: Mr Jones, what steps has the department taken to advise local health bodies on how reviews should be carried out and on the evidence that you expect to underpin them? Are you satisfied with the process in Tayside? What monitoring systems do you have in place?

Mr Jones: I am not aware of any guidance that we have issued on acute services reviews—Mr Aldridge may correct me on that. When we consider exhibit 7, I can say that I am not satisfied with progress in Tayside. It has taken longer than any of us would have liked to make progress on this. As part of the health plan, "Our National Health", we are creating a national expert group, which will advise NHS boards on how to develop issues such as this and to support boards in implementing reviews. NHS boards go through this only once every five or 10 years, but it is a continuous process throughout Scotland. There is a lot of experience throughout Scotland that we should be sharing; the expert group is being set up to do that.

Nick Johnston: At the 1999 accountability meeting, the department was concerned about the lack of a clear strategy on Tayside. The review is still not complete. Are you satisfied that a strategy is now in place?

Mr Jones: I am satisfied that we have a process, which Peter Bates has just taken us through, that will get the strategy in place and that the department will work alongside the NHS board in Tayside to ensure that we make progress on that as quickly as possible.

The Convener: We are reaching the end of an acute services review and it is still a process rather than a strategy. The Auditor General's report shows that one of the problems is that there is no strategy. Less than two years ago, at the accountability review meeting, the department expressed its concern at the continued absence of a clear service strategy for acute services in Tayside. I cannot see that strategy even yet. It all leads back to management, but I notice in paragraph 5.4 on page 19 that

"Tayside Health Board's auditor's report on the 1999/2000 accounts concluded that the contracting arrangements surrounding the appointment of the consultant were not fully in accordance with the board's standing orders and standing financial instructions."

Who was responsible for that?

Mr Brett: That is perhaps the one part of the report that has not been put as well as it might have been. I will explain. The health board at the time decided to appoint external management consultants to help with the process. We decided that there would be value in appointing consultants who had done previous work with the Angus NHS Trust and who therefore had a good deal of knowledge on the Tayside position. It was explained to the board that that was what we were doing and the board accepted that. The board has the facility to decide to put standing orders to one side, which I believe that it did on that occasion. The auditor quite rightly pointed out that the action was contrary to standing orders but we had pointed that out to the board when we asked it to make that decision.

The Convener: What are we to make of an accountable officer who does not act in accordance with standing orders and who is overseeing a system that has a lack of clear service strategy in the middle of an acute services review? It is not impressive.

Mr Brett: I am sorry, I—

The Convener: In the middle of an acute services review, there was a lack of clear service strategy, which still has not emerged. The accountable officer acted outwith the standing orders.

Mr Brett: I have done my best to explain that the board was informed of the position and made the decision in that knowledge. The decision was made when the process was beginning and we wanted to make urgent progress with it to ensure that the process got ahead.

Mr Raffan: I have a point for Mr Jones. Tayside is not the only health board area that has encountered serious difficulties and delays with its acute services review. Two of the health board areas that I represent, Forth Valley Health Board and Fife Health Board, have encountered what the ex-chairman of Fife Health Board might call even more serious difficulties with their reviews. Can Mr Jones tell us whether the time that it has taken Tayside to perform its review is significantly longer than the time taken elsewhere? Does he agree that the acute services review in Scotland has caused serious problems?

Mr Jones: That is quite right. Acute services reviews are always the most controversial parts of strategy development and can take a while to perform. A detailed review is under way in Glasgow and, as you say, Forth Valley Health Board and Fife Health Board are conducting reviews. I do not know whether Tayside Health Board's review is taking longer but, in hindsight, it is fair to say that we need a smarter and faster

system to move the processes forward. I have described the mechanism that we are setting up to do that.

Mr Raffan: That is important, as the issue comes down to the department's macro-management—not its micro-management—and how it sets out the strategy. The department should not pass the buck. When acute services reviews are set out, it is up to the department to lay out the framework for them.

Mr Jones: That is right. Another important issue is the interface between health board areas. It is important that, when one is thinking about a strategy in Tayside Health Board, one also thinks about the strategy in Forth Valley Health Board. That will ensure that there is a national approach, which we are addressing through the health plan.

The Convener: We will now deal with the unit cost of health care in Tayside and ask why it is relatively high.

Scott Barrie: Paragraph 8.17 of the report tells us that the department maintains statistics on the unit costs of health bodies. How does your department use those statistics to fulfil its role in monitoring the performance of the separate health bodies?

Mr Jones: I will ask Mr Aldridge to handle that question as it is on his area of expertise.

Mr Aldridge: We collect a range of information about the comparative performance of organisations across Scotland and about comparative unit costs. One of the difficulties that we have faced is in being sure that the comparative unit costs are collected on a truly comparable basis. We have to be cautious in how we use those costs. They have been used in the performance management and accountability review arrangements to challenge local health systems on why their costs are higher than costs in another area or, indeed, on why they are significantly lower, as that, too, might be an indication of problems.

Scott Barrie: You will be aware that Tayside Health Board's costs are much higher than the costs of any of the other parts of the NHS in Scotland. What action has been taken to address that?

Mr Aldridge: Such figures must be treated with some caution. It is true that costs are higher in Tayside but, if one takes into account the higher expenditure on hospital and community health services in Tayside—which results from factors such as the effects of the Arbuthnott formula on the area's funding—the excess is not as significant as it appears to be. That has to be taken into account.

Accountability and performance management reviews were undertaken, especially when the financial problems of Tayside became clear. Tayside Health Board may wish to comment on that, as it has been identifying where its costs are higher than elsewhere and where it might make efficiency savings to come into line with the rest of Scotland.

Mr Brett: We have a small population base and a medical school with the smallest catchment population of any in the United Kingdom. We provide a number of services because we are a teaching centre and the costs are spread over a smaller population.

We have high estate charges. We have a lot of estate, and Ninewells is a very expensive hospital in terms of capital charges. Tayside has a relatively elderly population, as the Auditor General states, which will bring our capital charge down in some respects, although our costs might be expected to be higher partly because of that. We have examined the issue intensively, and Mr White or Mr Wells may want to tell you what we have done.

Mr White: We analysed our capital charge burden in Tayside University Hospitals NHS Trust relative to those that are borne by other acute trusts in Scotland. If our capital charges were pro rata to what other trusts are bearing, they would be some £4.3 million less per annum recurring. It appears that Tayside University Hospitals NHS Trust is using relatively more and more expensive estate buildings, land and equipment to deliver services than are being used elsewhere in Scotland, and that is placing a cost burden on the population. The funding that is tied up in paying those sorts of costs would otherwise be available to pay for some of the other things that we have been discussing.

Scott Barrie: Why are the costs higher in Tayside than elsewhere?

Mr White: There are two factors. The first is the number of buildings that we have in both trusts and the value that has been placed on those buildings. Both Perth royal infirmary and Ninewells hospital are relatively new buildings and are valued accordingly. The capital charges that those buildings attract are therefore high relative to those of much of the estate elsewhere in Scotland.

Scott Barrie: Surely other health authorities and trusts have new buildings. Being parochial, I point out that Queen Margaret hospital in Dunfermline is new.

Mr White: It is. I would judge that the valuation of Queen Margaret hospital is slightly less than that of Ninewells hospital. However, Fife Health Board is not running anything like the number of hospitals that are being run in Tayside, relative to its population. That brings a cost burden. Fife has

community hospitals like those in Angus and Perthshire, but the volume of hospitals and the square metreage of estate that is employed in Fife is less for the population that it serves than the equivalent figure in Tayside.

The Convener: Is it not also true that Tayside received proportionately higher amounts of money than other health authorities did? You were receiving more income.

Mr Brett: That is true. Similar to what you heard when you were in Glasgow, the previous Scottish health authorities revenue equalisation formula meant that Tayside, along with Glasgow and the Lothians, was relatively over-funded in comparison with other parts of Scotland. Over 15 or so years, we returned to parity. I give credit to the people in Tayside—we managed that process

Scott Barrie: Mr Aldridge gave caveats about why it is difficult to compare the unit costs and why the comparisons are not as straightforward to make as they first appear to be. Is there any purpose to using unit costs as a basis for comparison?

Mr Aldridge: Yes. Having unit costs remains helpful, but they should not be taken as absolutes. They should be used as indicators of where questioning would be appropriate and to start a conversation or challenge about the position. It would be wrong to put too much emphasis on the precise figures that emerge from that exercise.

15:15

Scott Barrie: I am not sure whether my next question is for Mr Aldridge or Mr Jones—you can decide between you who will answer it. To what extent will the proposed performance management and accountability framework allow you to focus on comparative unit costs and quality of services?

Mr Aldridge: I will answer first. Mr Jones may want to expand on my answer. The new framework will allow us to do what you described, but will involve more than simply the relative unit costs of services. It will facilitate a much wider comparability exercise that involves different parts of the health service.

Mr Jones: I described the seven core elements of the new performance management framework, which concerns finance and efficiency. It also involves the rest of the core business and deals with the activity that is being undertaken on health improvement in a board area, partnership working with the rest of the public sector, involvement of community and patients in health service planning, clinical quality, clinical governance, access to services and staff governance. The new performance assessment framework focuses more widely than simply on the financial bottom line, which is what we used to use to run our business. The framework is more concerned with quality and how local communities are engaged.

Scott Barrie: Will that framework allow us to make better comparisons between different areas and avoid the difficulties that Mr Aldridge mentioned?

Mr Jones: Yes. For each matter, we will have a range of subindicators, which will be analysed over time for a health board area, and across Scotland. We will be able to compare directly how we are involving communities around Scotland and pick out areas that are doing that extremely well and areas where more effort needs to be concentrated.

Mr White: I return to the broad issue of benchmarking. As well as considering financial benchmarking, which, as Mr Aldridge says, allows us to ask questions and probe any apparent differences, we have made skill-mix comparisons across a range of departments and staffing levels with similar departments in similar organisations. For example, Ninewells compares quite closely with Foresterhill in Aberdeen, but it would be inappropriate to make that comparison for Perth royal infirmary, so to build a comparison for that we consider other hospitals of a similar type. Comparison is taking place at several levels, not just that of financial benchmarking.

Mr Wells: I would like to balance the picture in Tayside a bit. It is not true that all unit costs of Tayside services are above the Scottish average. Most unit costs of primary care services are below the Scottish average. People should be aware of that balance.

The Convener: That comment is welcome.

Brian Adam: I am rather concerned about the return on capital investment. Are you suggesting that there are too many sites, that the sites are not well utilised and that the formula is rather unfair on health authorities that have relatively modern premises, such as Ninewells and Perth royal infirmary? I would like to hear from the representatives from Tayside and the health department about whether that is an appropriate way of ensuring that a return on the money is made.

Mr Brett: The number of sites is largely a fact that we inherited. Some years ago, Tayside had more hospital beds per head of population than any other part of Scotland, partly because we had two EMS hospitals—Stracathro and Bridge of Earn—that were built during the second world war and were carried into the national health service.

We can take action on the situation. The biggest capital charge element that we face is the

Ninewells site because it is difficult to knock bits off Ninewells. However, we can still have discussions, particularly about whether the university will use parts of the site in the future. The trust is considering that possibility. In the longer term, as newer hospitals are built in other parts of Scotland, the situation will gradually balance out.

The Convener: The committee hates acronyms. Will you clarify EMS?

Mr Brett: EMS is emergency medical services. There were wartime hospitals at Bridge of Earn and Stracathro.

The Convener: We have been happily acronym free so far.

Margaret Jamieson: My question is to Mr White. Paragraphs 8.14 and 8.15 of the Auditor General's report record the action that the trust took to benchmark its costs against those of others and the resulting savings that have been identified. Why did that work not commence until 1999?

Mr White: I think that we did well to commence at that time. We started that comparison in the first few months of the trust's existence. We have made progress that has informed some of the efficiency savings that we made in the year from which we have just exited. The work to which paragraph 8.14 refers allowed us to formulate robust plans on which we were able to deliver. We did not delay when the new trust was created. We started that work well within our first year.

Margaret Jamieson: Is there evidence that the previous trusts used that system of benchmarking?

Mr White: The trust's director of nursing was instrumental in helping to take forward that part of the agenda, because she had been director of nursing in Dundee Teaching Hospitals NHS Trust, where she did such work. She had been with that organisation only about a year or less before the restructuring got under way in 1998.

Margaret Jamieson: Did the medical director follow a culture of benchmarking, consider service costs and how services should be delivered and study best practice throughout Scotland?

Mr Brett: If you will allow me to return to my previous role, I can say that such processes existed. The previous trusts were involved in a benchmarking club with teaching hospitals in other parts of Britain, so we compared our performance against those of Addenbrooke's, Leeds and other hospitals in England, because I was concerned that we should be efficient compared with UK hospitals and not just Scottish hospitals.

Margaret Jamieson: If you undertook that process, why are your costs still high?

Mr Brett: That is a fair point. The issues need to be continually revisited, but for year three of our recovery process, we are about to set up clinical review teams that will study in depth those clinical areas where we are significantly above the Scottish average. We plan to do that in the next six months, using such information, redesign and other techniques. We hope to have proposals to put to the unified board in October this year that will generate our efficiency savings for our final year.

Margaret Jamieson: The redesign techniques that you talk about have been tried and tested in other areas of the country. You are not showing me that you will reinvent them to suit the needs of Tayside. I still have concerns. If you are so adamant that you had the process in place, why did it not work?

Mr Brett: That is partly because the trust is now configured differently and we can now consider services—

Margaret Jamieson: But a hip replacement is a hip replacement—it does not matter whether there are one, two or more trusts. A hip replacement is a hip replacement, irrespective of the number of hospitals. That is the bald fact that individuals are concerned about.

Mr Brett: That is correct. We compared our hip performance pathway with that of other hospitals in Britain. We discovered that we were keeping patients in hospital longer than did other hospitals and that there did not seem to be a good reason for doing so.

Margaret Jamieson: What did you do about it?

Mr Brett: We visited other hospitals to understand what they were doing that was different. New practices were introduced as a result. Medicine does not stand still—

Margaret Jamieson: I am well aware of that.

Mr Brett: People need to revisit their procedures.

The Convener: Margaret Jamieson has elicited a queue of responses. Mr White and Mr Bates want to come in at this point.

Mr Bates: It is important that we convey clearly to the Audit Committee that, without doubt, the Auditor General has put his finger on something that we can and must do better. Improving performance is not a bolt-on extra but a continuing process that becomes part of the culture. All managers, clinical directors and clinical leaders in Tayside have to think constantly about their performance and to ask why they are doing things in a particular way. If someone is performing to as good or to a better quality anywhere else at a

cheaper cost, they have to ask how that is so and what can they do to fast-track improvements in Tayside. The Auditor General's point is fair.

I assure Mrs Jamieson that the three chairmen of the unified authority regard performance improvement as an important priority for managers and for all the clinical leaders. It is one of the things we in Tayside need to get motivated about, so that it is seen as part of everybody's responsibility. It is absolutely true to say that we have a way to go to get better at that.

Mr White: I want to reassure Mrs Jamieson that we are not reinventing the wheel. In 1999-2000, we looked at redesign in the Leicester royal infirmary, the Royal London hospital, the Royal Shrewsbury hospital, Edinburgh royal infirmary and the Central Middlesex hospital. We have applied what we learned from looking at all those hospitals. In November 1999, we gave a presentation to clinical staff to set out the examples of good practice and service change that we had seen at each hospital site.

Margaret Jamieson: The issues that you have described will be way up the clinical governance agenda. Individuals will have to answer to that agenda in terms of their clinical performance. If we are talking about benchmarking, something that will be new to the service is point of partnership. Mr Bates referred to that earlier.

The primary care trust has not been questioned very much today, but in any redesign of service, the most important partners are the primary care trust and the local authorities. Can we be given an assurance that those groups are on board? If they are not, whatever you implement is going to fall down like a pack of cards. I get the impression that Mr Bates and Mr Jones are talking about NHS Scotland or NHS Tayside; I do not get the same feeling from Mr White or from Mr Brett. I do not feel that they are buying into the new ways of working.

Mr White: Let me try to reassure Mrs Jamieson. Most of the questions have been specific to the trust. Mrs Jamieson is opening up an important area of questioning about the interface between the trust and local authorities. In the redesign work that we have done, we have invited primary care trust staff into the redesign projects. Indeed, we are going further than that, as the joint management forum that embraces all three health bodies is overseeing the whole redesign programme in Tayside. Mr Wells and I have an imminent meeting of the redesign team to talk about creating even closer joint working than exists at present. Perhaps Mr Wells could talk about the nationally recognised project in Perth that is drawing the health authorities and local authorities together into a redesign of services in a more fundamental way.

Mr Wells: A working partnership is extremely important. The main partners for us in the primary care trust are the local authorities and our acute trust colleagues. Indeed, the primary care trust has been structured to reflect the three local authority areas in Tayside. The project that Paul White has just referred to—the care together project in Perth and Kinross—starts life this week and brings together all the health and social care services in Perth and Kinross under one joint board structure. We are paying particular attention to partnership working arrangements.

The service redesign issues are extremely important if we are to move on from where we are now. The formation of a joint service redesign team in Tayside is an important cornerstone of that process. We are keen to work with our colleagues in the acute trust, not least because whatever the acute trust does impacts directly or indirectly on the primary care services that we provide.

15:30

Mr McAllion: I would like you to clarify exactly what savings are achieved as a result of benchmarking. Paragraph 8.14 refers to the benchmarking of medical and nursing pay and goes on to say that

"has led TUHT to reappraise its nursing establishment with a view to establishing more appropriate numbers of nursing posts."

I take it that that means that you have cut the number of nurses.

Mr White: Yes, we have reduced the number of nursing posts.

Mr McAllion: It would be nice if the report said that rather than hinted at it.

Mr Jones assured us that the quality of patient care cannot be compromised. Paragraph 8.14 tells us that you are reducing the number of nurses in Tayside and paragraph 8.16 talks about the scope for a reduction in bed numbers in Tayside. I cannot see how the quality of patient care can be maintained while you are cutting the number of nurses and the number of beds that are available. I do not think that that adds up.

Mr White: I will use an example to explain how such a change would take place. Some of the wards that we inherited at the beginning of April 1999 were not used to their full capacity, by which I mean that they did not have occupancy rates of 85 to 90 per cent, which would be the generally accepted upper levels of occupancy. Some of the wards that we inherited had occupancy rates of 40 or 50 per cent. That is clearly not a good use of resources. We examined the possibility of combining some of those wards and closing beds

that were being inefficiently used. Thus, the nursing posts were not filled as they fell vacant. In that way, the number of beds and the number of nurses were reduced without compromising the quality of care.

Mr McAllion: You are increasing the use of beds in hospitals so that more patients go through the beds week after week. Does not that make more likely the possibility of hospital-acquired infections, which are now a problem in Tayside?

Mr White: The situation that you describe should not make that more likely because the staffing levels and the skill mix of nurses should be appropriate to the number of patients in a ward and the dependency of those patients, which will include their susceptibility to infection.

Mr McAllion: However, if the nurses are expected to tend to far greater numbers of patients than they were in the past, surely their ability to perform as nurses is compromised because they will be more tired and stretched than they used to be—they will not be as good as they were when they were not under such fierce pressure.

Mr White: The nurse staffing levels that we have applied in the wards and departments across the trust are based on nationally recognised formulas. That is part of the benchmarking exercise. Tayside is not filling wards to a higher level or staffing them to a lower level than is happening elsewhere in the country. We are ensuring that the practice in Tayside follows the best accepted practice across the country.

Mr McAllion: Everybody tries to give positive answers and pretend that nothing bad is happening in the health service. Earlier, I believe you said that waiting lists would not increase in Tayside as a result of the attempts to balance the budget, but the report refers to your financial recovery plan from February 2000, which talks about not carrying out non-emergency elective surgery. That must lengthen waiting lists.

Mr White: That is not part of our recovery plan at this point.

Mr McAllion: But it was in February 2000.

Mr White: That is correct. We deliberately reduced the amount of elective activity because, at the end of December, the trust was 3,600 cases ahead on activity compared with the same period in the previous year.

Mr McAllion: Waiting lists must have increased at that time as a result of your decision not to carry out non-emergency elective surgery.

Mr White: That is correct—waiting lists increased.

Mr McAllion: As a result of policy?

Mr White: As a result of our trying to maintain a cash balance for the end of the financial year. During this year, we have brought waiting lists down. As I said in response to an earlier question, we are back on target. I stress that for most of last year we had no patients breaching charter guarantees. We had some at the beginning of the year but, since the summer of 2000, we have not had any patients breaching charter guarantees. We are back on track with our waiting list performance.

Mr Raffan: I want to follow on from Mr McAllion's point. We have talked about efficiency savings or cuts—whichever phrase one uses—but there is also the question of funding the development of new services. I am concerned that that may be stalled.

I understand that the health department does not monitor the balance between the provision of services within a health board area because that is up to the health boards themselves. I would like to pursue that point with the department on another occasion. There is already a gross unevenness of service in different health board areas in, for example, tackling drug misuse. Even if you achieve the targets that you have mentioned, and even given the reassurance that you gave Mr McAllion, is there not a danger that new services, or the development of existing ones, will not be funded as they might be in other health board areas that have balanced budgets? Is there not a danger that Tayside will fall behind?

Mr Bates: The answer to that question is central to why we are sitting here in front of committee members today. Mr McAllion is right: my answers are positive because I feel that we have to take a positive approach. In NHS Tayside, we have outstandingly good staff who are providing good quality services. They deserve strong and positive management and leadership.

If we continue to do everything we do at the moment in the same way and do not have the courage to make the sorts of decisions that need to be made—which the Auditor General has quite properly said we need to get on with making—not only will we not be able to make the investment in primary and preventive services that Mr Raffan rightly mentions, the deficit will simply grow and we will not achieve what we need to achieve. It is in the interests of the overwhelming majority of the Tayside population that we be allowed to get on and make those changes. Mr Raffan is absolutely right to raise the point. To go back to Mr McAllion's point, if we stand still and say, "We can't do anything about what we are doing at the moment, we've just got to get on and keep doing it in the same way," we will never move ourselves out of this position—and we have to move ourselves out of this position.

I would like to add one other thing to the answer to Mr McAllion's question. Mr White made the point that we have 270 beds that are currently taken by people who do not need them. Going back to the point that Mr Barrie raised, we must secure real partnerships and build on the links that we already have with local authorities to get that number down. A number of those beds will be needed to make progress on some of the other agendas, such as waiting lists. We have to get on and make those decisions. Without doubt some people will feel, when we make those decisions, that we are letting them down: we will not be able to please everybody all the time.

Mr Brett: To reassure Mr Raffan, I would say that as part of the use of additional funds last year, the joint management forum agreed to invest £2.7 million in primary and community care services. We were conscious of the need to invest in those services across Tayside and we did so in conjunction with our four local health care co-operatives and our three local authorities. You could ask, "Why did you not just offset more of the overspending on the acute side?" We did not do that, quite consciously, because we believed that the priority was to put right some of the long-standing deficits.

The Convener: I am aware that this particular market day is wearing late, but Peter Bates's positive view of a management worthy of the dedication of its staff neatly leads us into the last section, which will examine whether Tayside health bodies have improved leadership, governance and communication and look to the future.

Mr Quinan: Mr Jones, the ministerial task force identified an absence of health leadership, corporate working and governance and a lack of effective communication as important factors contributing to financial and other problems in the NHS in Tayside. Paragraph 8.12 of the Auditor General's report sets out what were the latest in a list of weaknesses in governance in Tayside health bodies. How do you satisfy yourself that the guidance that is listed in exhibit 5 of the report is being followed?

Mr Jones: I met the Tayside task force only relatively recently, just as we were bringing the task force's work to a close. Members of the task force spoke positively about the changes that have taken place in Tayside over recent months. Those changes have addressed issues including leadership and communication. As a result of the changes, significant improvement has been made in those areas. The department will review formally all those areas as part of the performance assessment framework that has been referred to on a number of occasions today.

It is absolutely critical that the NHS has strong, able leadership in each NHS board area. That leadership starts with the chairmanship of the boards and has to cascade through all the organisation's structures. The performance assessment framework, which we will use to review directly a board's performance, will pick up on the areas that need improvement. As I said, we will publish the results of those reviews.

Mr Quinan: I will direct my next question to Mr Brett. Paragraph 8.9 of the Auditor General's report summarises the new protocols that have been introduced to control the approval of service developments. Do those protocols overcome the previous weaknesses?

Mr Brett: Yes, I believe that that is the case. There is now a much firmer grip on that. There is a clear understanding between Mr White, Mr Wells and me. Major issues are brought to the joint management forum that was set up soon after the task force arrived. We have recently reviewed the forum's role and remit. That means that any key decision is taken in that group prior to its coming to the board. I am confident that we have the mechanisms in place to deal with the matter.

Mr Quinan: That is an interesting reply, given the reference that is made in paragraph 8.9 on page 35 of the report to the protocols that would

"help control the approval and use of additional resources for service developments."

Those protocols created major problems in the past. Do you believe that those protocols are a product of the relationship between the trust, the university and the teaching hospital, or are they a product of the unfortunate circumstances of additional staff being brought on board in Perth and Kinross and in Dundee?

Mr Brett: Mr White might like to comment. We have come a long way since that time. Mr Quinan is highlighting the events of two years ago, and the situation now is much more positive. The £2.7 million that I mentioned was the outcome of joint decision making between the local health care co-operatives and the three local authorities. The decision-making process is much more open. I must also stress that we now have a much greater involvement of staff in all our processes. That has been a positive development.

Mr Quinan: I ask Mr Brett to give us an absolutely straightforward assurance that it is no longer possible for anyone in Perth and Kinross or in Dundee to decide to employ 200 extra nurses or other staff without anyone in the finance department knowing anything about those decisions.

Mr Brett: I am happy to give members that assurance.

Mr Quinan: Thank you very much.

Mr Bates: For the record, I want to correct an earlier error that was made in a reference to the external auditor's comment about the letting of the contract to the consultants. I want members of the Audit Committee to be assured that I am aware that there can be no room for complacency.

I have said that I want the review of the board's standing orders to be completed urgently. That is a continuing piece of work that we will have in mind for the unified board. As the new chairman, I want, as part of that work, to see a careful reappraisal of the scheme of delegated powers to senior managers because, in any organisation, one of the key things to do is to identify who believes they have what power to make what decisions. I feel strongly that, although we have to have freedom to manage and to get on with things, there has to be a proper and transparent recording of decisions that have been made. I intend to have that review of standing orders and delegated powers completed by the summer, ready for implementation by the new board.

The Convener: I detect that your past experience is now standing you in good stead.

15:45

Mr Quinan: I would like something clarified. Mr Brett said to me that the protocols would prevent the situation of someone being able to employ upwards of 200 staff—either in Perth and Kinross or in Dundee—without reference to anyone else. However, you appear to have just said that you require a change in the standing orders and a clarification of the delegated powers to guarantee that such a circumstance would not arise again.

Mr Bates: My exact words, I think, were—and I have them written down in front of me, so I am sure that the *Official Report* will show this—about a review of the standing orders and the scheme of delegation. I want to be clear, and this is an important point. Understandably, we have concentrated on an awful lot of things that have gone wrong. However, during the past nine months or a year—and I think that Mr Jones referred to this in response to the debriefing from the task force—an awful lot of things have been put in place in Tayside. For example, the way the three chief executives and three directors of finance are having to work together to manage the agenda, and the introduction of a much tighter system of accountability, are positive things. It is important that we get that over. This is not a case of our saying, "We've done that now and it's okay." My job is to ensure that we continue to scrutinise. There is always room for improvement. I have not been involved in public service organisations for more than 30 years, knowing all the mistakes that I have made as a senior manager—and there have been many of them—without knowing how easy it is to make mistakes.

I did not say what Mr Quinan suggests I said. There may well need to be changes, but what I have instructed is a proper review.

Mr Quinan: Thank you, Mr Bates. That makes things clear for us—although inferences may be drawn from a comparison of what you said with what Mr Brett said.

My final question is to Mr Brett. Paragraph 8.11 of the Auditor General's report refers to the "Recovery through Modernisation and Investment" report and it addresses a range of measures that are aimed at addressing the task force's criticism of leadership, governance and communication. Those measures include enhanced performance management to ensure that information is shared among the Tayside health bodies. Is such information now available? What benefits has it achieved?

Mr Brett: Information is available on a number of fronts. The measure that would probably be of most interest to the committee is that, for the past six months or most of the past financial year, we have had a joint monthly financial report. That is prepared by the three finance directors. It comes to the joint management forum and goes to all three health bodies in Tayside. That was commended by the task force. I believe that something similar will be commended to all other health systems in Scotland.

Having such a report means that we can all see clearly what is happening, where there are pressures or problems, and whether efficiency targets are being met. It is an open document, available to everybody. We need to build on that and include other shared information. We want to improve on a number of other areas.

Mr Raffan: I want to ask Mr Jones about the ministerial task force. We had the interim report of that task force in June 2000. Then, on the department's advice, or probably his own advice, the minister decided to stand down the task force in November. The interim report therefore became the final report. That is rather ironic, and perhaps Mr Jones will agree.

One of the criticisms in Tayside has been to do with communication. Would it have been in the interests of reassuring the people of Tayside if the task force had actually made a final report and said very clearly and very publicly at that time—it has been said since—that real and good progress was being made and that the task force was therefore being taken out?

Mr Jones: It may not have happened as well as it should have, but it did happen. The minister came to Tayside as she was closing down the task force and when she announced the appointment

of Peter Bates and another chairman in Tayside. She said that the task force work was complete and had been successful. There have been significant changes as a result of the work of the task force.

Mr Raffan: There is always a danger when interim reports become final reports—

Mr Jones: I take your point.

The Convener: We have covered a lot of ground and have acknowledged some problems in regard to confidence in health management in Tayside. We have looked at management continuity; one thing that bothers me is that change seems to have been forced by outsiders—including task forces—in many ways as well as by bad budgeting practices and major public disquiet. We have looked at some of the problems in some detail.

To finish, I would like to give Mr Bates the opportunity to look ahead. Given the latest list of weaknesses set out in paragraph 8.12 of the report, what assurances can you give that the NHS in Tayside is now being managed in the best way?

Mr Bates: I genuinely want to thank the Audit Committee for taking us through some important matters in a way that helps to explain to the wider world the fact that the roots of many problems go back a long way.

It would not be prudent to mislead the Audit Committee into believing that someone such as a new chairman can come in with quick fixes, wave a magic wand and everything will be fine. There are new arrangements for the unified board, and there are now three chairs in place in Tayside who are absolutely determined and committed to working together and to be open and transparent with the citizens. We have an outstandingly good work force, with trade union leaders and staff-side leaders who have made clear their interest and willingness to work in partnership with us. The new board will bring the local authorities round the table in a new way. Those factors are good for the future, but there are major challenges that the committee has exposed today and choices that will have to be made quickly so that progress can continue.

It would not be flippant to say that, in the next 18 months to two years and onwards, we will need a great deal of support from MSPs and others in the wider world to help us see changes through. I am extremely positive, but I am also realistic. We have started a long journey in the right direction. We know where we have to go, but there will have to be changes. The culture of accountability in the organisation and the real governance agenda of building on our strengths but waking up others to the culture that needs to be in the organisation will be a continuing challenge for me. You can be assured that I will meet that challenge to the best of my ability.

The Convener: We are dealing with services that affect us all and our wider communities. This meeting is not the end of the process. The committee will now consider the evidence that we have received. We will decide what further evidence or information we need and we will produce recommendations for action. A report will be produced as soon as possible within an appropriate time scale.

I thank all the witnesses. The session has been long, but important information has been given to us. That decision makers are accountable very publicly and openly is an important part of the new Scottish democracy.

I thank members of the public who have attended. I know and share their concerns and very much appreciate their presence today. They have helped to make this the best attended meeting of the Audit Committee to date. That is a good sign.

I thank the staff of Dundee City Council for their hospitality and efforts in facilitating this meeting and the Parliament staff who have helped to make the meeting possible.

15:54

Meeting adjourned until 16:05 and continued in private until 16:20.

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