AUDIT COMMITTEE

Tuesday 15 May 2001
(*Afternoon*)

Session 1

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AUDIT COMMITTEE
8th 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:

Mr Robert Black (Auditor General for Scotland)
Mr John McAllion (Dundee East) (Lab)
Shona Robison (North-East Scotland) (SNP)

WITNESSES

Miss Pamela Ballie (Former Director of Finance, Perth and Kinross Healthcare NHS Trust)
Mr Peter Bates (NHS Tayside)
Mr Tim Brett (Tayside Health Board)
Mr Frank Brown (Former Chief Executive, Perth and Kinross Healthcare NHS Trust)
Mr Philip Colville (Former Director of Finance and Information, Dundee Teaching Hospitals NHS Trust)
Mrs Frances Havenga (Former Chairman, Tayside Health Board)
Mrs Caroline Inwood (Former Director of Nursing, Perth and Kinross Healthcare NHS Trust)
Sir William Stewart (Former Chairman, Tayside University Hospitals 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

The Chamber

Scottish Parliament

Audit Committee

Tuesday 15 May 2001

(*Afternoon*)

[THE CONVENER *opened the meeting in private at 14:02*]

14:23

Meeting continued in public.

National Health Service (Tayside)

The Convener (Mr Andrew Welsh): I welcome our witnesses and thank them for travelling to Parliament to give evidence. Your participation, as part of the committee's attempt to make the facts of the situation public, is appreciated. Our remit is not to blame, but to illuminate and to recommend improvements, when appropriate. I welcome our colleagues, Shona Robison and John McAllion, who are not members of the Audit Committee but who have a local interest. I also welcome the Auditor General for Scotland and his team.

Today, we will take evidence from three groups of witnesses. First, we will talk to former senior managers of Perth and Kinross Healthcare NHS Trust and Dundee Teaching Hospitals NHS Trust. We will then hear from senior managers of the current Tayside Health Board and Tayside University Hospitals NHS Trust. Finally, we will speak to the former chairpersons of Tayside Health Board and Tayside University Hospitals NHS Trust. I welcome everybody to the meeting, including Mr Peter Bates, the current chairman of Tayside Health Board.

We will consider additional evidence that has been made available to us by former chairpersons and senior managers in Tayside health bodies, in relation to evidence that was provided to us by current managers at the Audit Committee meeting in Dundee on 2 April.

We will consider three main areas today: first, the extent to which incoming managers were provided with information on a potential financial deficit; secondly, controls over the financial impact of staff recruitment and developments in cancer and renal services; and, finally, management and accountability in Tayside health bodies.

I will start by asking Mr Frank Brown and Mr Philip Colville general questions about the transfer of responsibility for the finances of Tayside health bodies in April 1999. Was it your clear understanding that the new Tayside health bodies would face financial problems?

Mr Frank Brown (Former Chief Executive, Perth and Kinross Healthcare NHS Trust): The financial position of the Perth and Kinross Healthcare NHS Trust was well known over the past three years, in that increasingly we had to rely on the use of non-recurring expenditure to balance our base budgets. That information was well known within the health service, to the health department and to the incoming trusts.

The Convener: Mr Colville, was it your clear understanding that the new health bodies would face financial problems?

Mr Philip Colville (Former Director of Finance and Information, Dundee Teaching Hospitals NHS Trust): Yes, it was obvious for some time before 31 March. Back in September, I had briefed the council of clinical directors at Dundee Teaching Hospitals NHS Trust that I thought there would be a £9 million problem for the new acute trust. A substantial chunk of that related to Perth and Kinross, to which Frank Brown has referred. That was well known about in Tayside at the time. We were aware of pressures in Angus owing to the suspension of a couple of surgeons, which meant that work had to come to Ninewells hospital.

A few days later, at the annual public meeting of the trust at the end of September, Derek Maclean, the medical director of the trust, put the figure of £9 million into the public domain. After that, when, as part of the recruitment process for the directors of the new trust, the three candidates to be chief executive met the existing executive directors of Dundee Teaching Hospitals NHS Trust, I made it clear to each candidate that the trust faced a significant deficit. It was only fair that they should consider the job in its totality and realise that they would take on a difficult inheritance if they were offered the job and accepted it.

The Convener: Was it your responsibility to make the situation clear to your successors?

Mr Brown: Yes, I felt a clear responsibility in managing the transition between the old trust and the new trust. At our first meeting with the chairman designate of the new trust, we made it our business to draw attention to the situation in Perth and Kinross Healthcare NHS Trust from our perspective. That view was enhanced at various officer meetings from September to March 1999.

The Convener: Mr Colville, was it your responsibility to make the situation clear?

Mr Colville: I will make a general comment about openness. There was a clear message after the 1997 general election that the new Government wanted openness and partnership.

From that point onwards, openness within the health system in Tayside increased another notch. I do not think that anyone specifically told me that I had to brief Colin Masson on the financial affairs, but I took it on board that it was my responsibility to ensure that he knew about them. At the time, I was meant to be taking up a finance director post at Yorkhill in Glasgow and I received a similar briefing from the outgoing finance director there. At that stage, openness was part of the game.

The Convener: Mr Brown, are you satisfied that you generally succeeded in making the potential position clear?

Mr Brown: Yes.

The Convener: Mr Colville?

Mr Colville: I am clear in my mind that both Paul White and Colin Masson were aware that the new trust would have a significant deficit. I cannot remember two and a half years on whether I quoted the figure of £9 million explicitly to them, but I certainly had conversations with both of them about the difficult financial agenda that they faced.

14:30

The Convener: We shall look at the details in due course, but will you confirm that, at the outset of the new health authorities in April 1999, the two new trusts and Tayside Health Board were aware that they faced inherited major financial problems from their predecessors and that they knew the general size and details of those problems?

Mr Brown: From the Perth and Kinross perspective, yes.

Mr Colville: I do not know whether they knew the sheer quantum of the deficit—whether it would be £9 million, £10 million or whatever, but they were aware of the extent of the Perth problems and, I think, of the general problems.

The Convener: But they knew that there was a major financial problem?

Mr Colville: They must have known that it was a large multi-million pound problem, but whether they thought it was £4 million or £10 million, I do not know.

The Convener: I ask Margaret Jamieson to discuss the problems that were inherited prior to 1999.

Margaret Jamieson (Kilmarnock and Loudoun) (Lab): I wish to ask Mr Colville about the evidence that the committee heard at its earlier hearing to which he referred in his letter to the convener. Certain senior managers from Tayside University Hospitals NHS Trust and Tayside Health Board said that they were shocked to discover the extent of the previous trust's use of non-recurring expenditure to balance the books. Mr Colville said in his letter that there was a lack of clarity in the relationship with the health board at that time. How much reliance was placed on non-recurring funds? Were the shadow board for the new trust and the department aware of that practice?

Mr Colville: I shall start with the relationship. The health board in the Lesley Barrie and Nigel Young era was different from that in the Tim Brett and David Clark era in terms of openness and how they went about their business.

Margaret Jamieson: Will you explain what you mean by that?

Mr Colville: I regard Tim Brett and David Clark very highly. They are open. David shared with us what the five-year financial time horizon looked like. Prior to that, it was more difficult to understand what was going on and what the thinking of the health board was. There were not many strategies—there was no road map to help the trust. Questions were asked about the style of the managers. I experienced an instance in Angus—perhaps Frank Brown had other problems—when Lesley Barrie and Nigel Young authorised a development. My people started the development, but the finance director at Tayside Health Board knew nothing about it and no money was set aside for it. Eventually, the trust-us-and-we-will-see-you-right approach cut no ice. We reached the stage where we would not make a move until the development was signed off in blood. We worked with Tim Brett and David Clark in a much more open, trusting and productive way.

I turn now to your question about non-recurring money. In the last year at Dundee Teaching Hospitals NHS Trust, we probably had three main areas of non-recurring money, other than waiting list initiatives, some of which tended to be for a short term.

We had a difficult relationship with Fife Health Board. More patients were coming across the Tay bridge to be treated in Dundee. Those patient numbers were increasing far faster than the funding was increasing. Affectionately or otherwise, we referred to the problem as the tariff equity problem—there may be some comments about the Fife tariff equity problem. In essence, that meant that referrals were coming across from Fife but the money was not following. Fife Health Board was not prepared to reduce the flow of patients but was not prepared to pay for them either. The management executive seemed reluctant to step in and force the issue. Therefore, to a degree, part of the annual contract settlement with Fife Health Board ended up with a non-recurring balance because Fife did not have enough recurring money to meet its obligations.

We had some non-recurring money from Tayside Health Board, but that tended to be project specific. Some of that money related to Dundee royal infirmary where there were some transition costs. For example, staff moving from Dundee royal infirmary to Ninewells hospital were entitled to excess travel reimbursements for four years. There was also the cost of physically moving equipment from one hospital to another. Therefore, some non-recurring money was targeted at non-recurring expenditure.

There was also non-recurring money associated with King's Cross hospital and the limb fitting centre in Broughty Ferry. It was intended that those services would come to Ninewells within a couple of years and that at that point, the non-recurring funding and expenditure would cease. Therefore, our non-recurring funding was matched, in the main, by non-recurring expenditure.

Right at the end of 1998-99, we received a large rates rebate from the council. We allocated a substantial proportion of that to deal with year 2000 issues. Various non-recurring expenditure was also made on the estates side.

We tried to balance the non-recurring income with the non-recurring expenditure and to keep it separate from recurring income and expenditure, but that was not always terribly easy.

Mr Keith Raffan (Mid Scotland and Fife) (LD): I want to pursue one point, although I do not want to go too far up the cul-de-sac. I find the business of the relationship with Fife Health Board extraordinary. How long was Fife Health Board sending an increasing number of patients across the Tay bridge without paying for them? Were there no systems in place to deal with the situation?

Mr Colville: The trend had built up over the three or four years up to 1998-99. Previously, when I was in the management executive in Edinburgh, I was responsible for developing contracting guidance. As part of that remit, I was asked by Don Cruickshank, who was then chief executive, and Mike Collier, the finance director, to develop a disputes procedure to arbitrate in the event of a contractual dispute between a health board and a trust. However, I do not think that the guidance was ever used. The attitude of those at the centre was very much, "Don't force us to use it because it will be a bruising experience for you if you do." One of the imperfections of the contracting mechanism was that if there was a head-on clash, there was not enough money in the system to oil the wheels and solve the problem.

Mr Raffan: Can you put a figure on the problem?

Mr Colville: From memory and from re-reading some of the papers last night, I think it was of the order of a third of a million pounds. To put it in perspective, that was on a £10 million contract.

Margaret Jamieson: You have indicated one of the pitfalls of the contracting regime. Do you believe that the financial position in which the health service bodies in Tayside find themselves stems from that era?

Mr Colville: The contracting mechanism itself is not the source of all evil. In Tayside, we had a good information technology team that developed a contract management system that allowed the Tayside University Hospitals NHS Trust and others who used the same system to manage the financial side of contracting relatively inexpensively. There are all sorts of stories about legions of bookkeepers creating invoices, but in Tayside, I believe that we managed the financial side reasonably well and reasonably cost-effectively.

The problems of the contracting environment were more about attitudes and the fragmented nature of things. There were general practitioner fundholders who may not have been trying to go in the same direction as the health board, and the two neighbouring health boards—Tayside Health Board and Fife Health Board—were diverging. Ninewells hospital was sitting close to the border between the two health boards. Both health boards had to sing from the same hymn sheet in terms of cancer strategy. It was difficult for Dundee Teaching Hospitals NHS Trust and Tayside Health Board to develop cancer services when, in a sense, the 10 per cent minority user of the services was not prepared to put money into the kitty.

Margaret Jamieson: Was there no service level agreement, irrespective of the contracting processes?

Mr Colville: Yes, there was, but service level agreements can only reflect the consensus or will between the parties to the negotiations.

Mr John McAllion (Dundee East) (Lab): I want to be clear about the situation between Fife Health Board and Dundee Teaching Hospitals NHS Trust. When Keith Raffan asked you whether you could put a figure on the trend for the three or four years until 1998-99, you said £30 million. Was that the value of the contracts over that period or was that—

Mr Colville: The annual contract value was of the order of £10 million. The value of the tariff equity problem, as we called it, was about £300,000, but that was £300,000 at marginal cost, so it reflected quite a significant increase in percentage terms in the number of patients over that period.

Mr McAllion: What part of the £9 million deficit, which you mentioned was passed on to the new trusts in 1999, could be attributed to the problem with Fife Health Board?

Mr Colville: We are talking in the order of a third of a million pounds. It is not a major issue in the context of the total deficit in Tayside. I was merely trying to illustrate what non-recurring funding we had, and what the problems were in terms of recurring and non-recurring expenditure funded from that non-recurring income.

Mr McAllion: You also mentioned that under their regime, Lesley Barrie and Nigel Young authorised new services without the knowledge of the director of finance of the health board. Was that the source of all the £2 million-worth of new services that were ordered? Did it come from that level?

Mr Colville: No. I was talking about relatively small developments in Angus, but I was using them to illustrate the management style of Tayside Health Board at that time. For example, there was a lack of openness, which led to difficulties in terms of relationships, and there was a lack of a strategy or road map to show where trusts were expected to go. Certainly in the finance director community, we could all see that funding for Tayside Health Board would reduce over time compared with that for other health boards, given the move to funding parity. We could see the financial pressures coming, but without the road map it was difficult to see where we were supposed to go.

Mr McAllion: So you are telling us that the management style under Miss Barrie was a contributory factor to the deficit?

Mr Colville: I believe that it was. That is one of the areas where the seeds were sown from far back.

Margaret Jamieson: You forecast an annual deficit of £9 million six months before the new trust was formed. To what extent did you make that forecast available to the then board of Dundee Teaching Hospitals NHS Trust, the shadow Tayside University Hospitals NHS Trust, and the Scottish Executive health department?

14:45

Mr Colville: The figure of £9 million came from the September meeting of the council of clinical directors. That was a gathering of about 20 of the senior clinicians from Dundee Teaching Hospitals NHS Trust. Usually monthly, they would meet the senior managers of the trust. It would be highly unusual for non-executive directors to be at those meetings. However, I felt that the meetings were important, in trying to keep communications going between managers and clinicians. I felt that I had a duty to the clinicians to try to set the scene of how I saw the financial agenda developing.

Derek Maclean reiterated that figure of £9 million at the annual public meeting a couple of weeks after the September meeting. I expect that most of the non-executive and executive directors of Dundee Teaching Hospitals NHS Trust would have been there. Some people from other trusts and from Tayside Health Board would also have been there. I cannot recall at what stage the appointment process for the new executive directors of the new trusts was at that time. The directors, other than the chief executives, certainly had not been appointed and I do not know whether the chief executives had been. For example, I do not know whether Paul White would have been at that meeting. I am sure that Colin Masson would not have been.

I would have to go back to board minutes—which I have not looked at since leaving the trust—to see to what extent at monthly board meetings I repeated or expanded on the sort of comments that I have made.

Margaret Jamieson: You referred to a meeting of a council of senior managers. Was a minute taken of that meeting?

Mr Colville: Minutes should have been taken. The meeting would have involved the senior managers of the trusts. They would tend to be the executive directors of the trusts and, as I said, about 20 of the senior clinicians—clinical directors, surgeons, clinicians and so on from across the trusts.

Margaret Jamieson: So, will there be a minute somewhere?

Mr Colville: There should be. It will be from sometime about mid-September 1998. In fairness to Paul White, Colin Masson and others in the new trusts, I do not know to what extent they would have access to the minutes of such meetings. I am sure that they would have seen minutes of board meetings, but the council of clinical directors meeting was slightly less formal than a monthly board meeting in public.

Margaret Jamieson: I would like to ask Frank Brown what reliance was placed by Perth and Kinross Healthcare NHS Trust on non-recurring funds. Were the board and the shadow board for the new trust made aware of that practice?

Mr Brown: From 1996-97, Perth and Kinross Healthcare NHS Trust relied increasingly on the use of non-recurring funds to allow the trust to meet its three financial targets. That was mainly due to contract income being less than the trust had expected for the services that it had been contracted to provide. It was also due to increased

activity—particularly emergency activity—at Perth royal infirmary. There were two cost pressures coming from opposite directions.

The trust board received a monthly report from all the executive directors. I know that each month, the finance director reported the financial position by way of a commentary. That commentary included very detailed financial pro forma documents that were sent on to the management executive. The Scottish Office health department and the trust board received exactly the same documentation.

At our first meeting with health department officials, in October 1997, the department was aware of the use of non-recurring funds. We were invited to attend because, at that time, we were forecasting that we would not meet our three financial targets.

Margaret Jamieson: At those meetings, was the accountability review process ever discussed in greater detail? Were you ever able to explain why you had to go down that road, taking into account what Mr Colville said about the lack of strategic direction from the health board to the trusts in Tayside?

Mr Brown: I was never part of the accountability process, which is an annual process involving the chief executive of the NHS in Scotland. However, when we met the officers from the department in October 1997 and in 1998, we gave them written submissions detailing why Perth and Kinross Healthcare NHS Trust was being required to use non-recurring moneys.

Margaret Jamieson: You say that you were not part of the accountability process, but were not you the officer who was responsible for the finances?

Mr Brown: Yes. I was appointed in 1997, but when I said that I was not accountable, I meant that I was not part of the formal accountability process, in which there was an annual meeting with the department about the health board's contract. However, I was part of the general accountability process.

Margaret Jamieson: We took evidence that indicated that a great deal of negotiation took place in late 1998-99 on a recovery plan for Perth and Kinross Healthcare NHS Trust. To what extent do you consider that the final plan that emerged from those negotiations represented a robust way forward that should have allowed incoming managers to feel confident that the expenditure on health services in Perth and Kinross would no longer have to rely on non-recurring expenditure?

Mr Brown: The Perth recovery plan went through several versions before it was agreed around February and March 1999. That recovery plan would not have brought the trust into recurring balance; there was a deficit. I cannot speak to the robustness of all the schemes, but I know that in some of the schemes that I inherited as director of operations—for instance, the transfer of the Murray royal hospital kitchen services to Perth royal infirmary—the figures have proved to be robust. There was going to be a gap, because the plan that we put in from all our resources would not have matched the £3.3 million.

Margaret Jamieson: Were you happy to sign off the final version? Were you satisfied that everything had been done that could be done?

Mr Brown: I would have preferred to leave a plan in March 1999 that left the trust in recurring balance. We did all that we could within our resources to make the financial position as good as it could be, but we knew that there was a gap.

Margaret Jamieson: Who were the other signatories to the plan?

Mr Brown: The plan was finally signed off by the health board chief executive and the chief executives of the incoming trusts.

The Convener: You said that there was a gap. Can you give us a figure for that?

Miss Pamela Ballie (Former Director of Finance, Perth and Kinross Healthcare NHS Trust): The value of the Perth and Kinross Healthcare NHS Trust recovery plan equated to £1.8 million. Of that, £500,000 was associated with changes of service configuration from the acute services review, which has not been fully implemented in Tayside. That £1.8 million still allowed for a recovery plan of £1.5 million.

The other aspect of that, as part of the overall recovery plan for the Perth and Kinross Healthcare NHS Trust situation, was that Tayside Health Board, in acknowledging the fact that there had been increases in activity, was prepared to put in additional investment of some £2.7 million. The investment by Tayside Health Board and the action plan that Perth and Kinross Healthcare NHS Trust developed to be implemented by the two new trusts fully covered the recurring deficit.

Shona Robison (North-East Scotland) (SNP): For how long did the finance director report monthly to the trust board that there was a financial problem, before officials from the management executive met the trust? How long had that gone on for? When did the practice of using non-recurring revenue stop?

Mr Brown: The finance director—Miss Ballie can speak for herself—reported monthly to the trust board on the complete financial position of the trust. I cannot remember the date of the first meeting at which she mentioned the use of non-

recurring moneys, but it was certainly in and around 1997, or perhaps slightly earlier.

Shona Robison: When did officials from the management executive first meet to discuss—

Mr Brown: October 1997.

Shona Robison: So the practice had gone on for a period of months prior to that.

Mr Brown: Yes; it had built up over the year. It was obvious from the figures in the forecasting documentation that the trust gave to the management executive that we were not going to make our three financial targets at the end of the year.

Shona Robison: Was one of the outcomes of the meeting with officials that the practice would stop?

Mr Brown: It was felt that the board and trust would seek to put the situation into recurring balance by the end of the financial year.

Shona Robison: Did the practice of using non-recurring revenue stop at that point?

Mr Brown: No.

Shona Robison: For how long did that practice continue?

Mr Brown: The use of non-recurring moneys effectively continued until the end of the life of Perth and Kinross Healthcare NHS Trust.

Shona Robison: That happened although that was part of the problem that people were trying to address.

Mr Brown: Yes. Each year we tried to reduce our use of non-recurring money by increasing efficiency savings. However, the pressure of increased activity and lower contract income was too much to allow us to close the gap. In reality, we never closed the gap.

Shona Robison: So, although solutions had been put in place, the issues that were causing the problem in the first place continued.

Mr Brown: Yes. The issues were that there was increased activity, but less income.

The Convener: The new authorities knew that there would be continuing non-recurring expenditure. Did they know by how much? I am still playing about with the figures of £1.8 million and £1.5 million that were mentioned.

Mr Brown: Perhaps my earlier response about the recovery plan for Perth and Kinross Healthcare NHS Trust has confused matters; Miss Ballie gave the truer overall position. The Perth and Kinross element amounted to £1.8 million, but the overall plan was to reduce the £3.3 million of recurring money from the trust.

The Convener: If you were a member of the new authority, could you be confident that you would no longer have to rely on non-recurring expenditure in Perth and Kinross?

Mr Brown: Yes.

The Convener: There are no other questions on that, so we will move on to consider the management information that was available to the new trust managers.

Scott Barrie (Dunfermline West) (Lab): We have heard evidence that one of the difficulties that the new trust experienced was in the disaggregation of information from the previous trust to provide robust budgets for 1999-2000. In your opinion, were there any specific limitations in the financial management system that was used by Dundee Teaching Hospitals NHS Trust that would have contributed to such difficulties?

Mr Colville: I do not think so. The Highways Agency, for which I currently work, is a reasonably large organisation that has been running for years on cash accounting. I recently shared with its finance director what sort of financial reports I was used to seeing when I was finance director at Dundee Teaching Hospitals NHS Trust. He was aghast at the level of detail in those reports, which was far greater than the detail he is used to dealing with at the Highways Agency. Our financial systems were developed by an in-house team at Tayside, which I believe gave good information. We were particularly fortunate in Dundee to have high-quality management accountants in my team. As a result, there should have been quality information.

One of my tasks when I arrived at Ninewells hospital—although for a number of reasons it took a lot longer than I hoped—was to try to pick up the Dundee royal infirmary transfer business case to find out what savings had been achieved and what still needed to be achieved. In order to do that on the nursing budget side, we went right back to 1992 when the business case was initially developed. We were able to track the nursing compliment—or the nursing budget—by grade, by whole-time equivalent, and for each ward in each speciality. That was a massive amount of information. Perhaps one of the reasons why it took us so long to do that particular exercise was that so much information was available.

Scott Barrie: When the trusts in Tayside were reorganised, was the financial information that was available comprehensive and robust?

Mr Colville: Yes, and in terms of robustness, KPMG had been Dundee Teaching Hospitals NHS Trust auditors from that trust's inception. At audit committee meetings, around annual accounts time, the chair of the audit committee would turn often to the KPMG director who was responsible

for the audit of many NHS trusts and ask how our financial performance and our financial management compared with other trusts throughout Scotland. That director's answer was that it was better than average.

15:00

Mr Raffan: I am not an accountant, but such a mass of detailed information can be a problem. I know that that is the case for parliamentarians, because sometimes one cannot see the wood for the trees. It is all very well having extremely detailed reliable information, but was the right use made of that information? Mr Colville said that, because he had so much information, it took a long time to make decisions. Were you capable of managing such a mass of detailed information? Was it necessary to have such detailed information?

Mr Colville: We were trying to demonstrate the extent to which the savings that were envisaged in the outline business case had been delivered, before we closed Dundee royal infirmary. We were also trying to clarify what further savings we were going to achieve when that closure happened. It is for those reasons that the process took a long time. We were going into a lot of detail in order to be able to build things back up to a high level again.

Mr Barrie said rightly that the ability to interpret data and information is important. We were fortunate to have some good management accountants at Ninewells hospital. Perhaps it is a reflection of the economy of Dundee that we were able to recruit and retain first-rate staff on NHS salaries. That would have been more difficult if we had been in Edinburgh. When Colin Masson came on board and we were going through the parallel running phase, he commented on the quality of staff that I had in my team.

The quality and the information existed. At Dundee Teaching Hospitals NHS Trust we were using that quality information effectively to understand our financial position. I cannot speak for the new trust, but it should also have been able to do that.

Scott Barrie: On the new trusts, some six months prior to April 1999, the shadow trust was in place. What assistance and financial information were provided to the shadow trust in that period so that it could set its budgets for 1999-2000?

Mr Colville: The shadow trust may have been up and running at that stage. The finance directors and all the other directors—apart from the chief executives—were appointed during November. In Tayside, two steering groups were set up to try to facilitate the emergence of the shadow trust and the new trusts. Much information would have been communicated at chief executive level in those forums. I communicated informally with Colin Masson about the information that I had. During that transitional period, in particular during January to March, he would have spent time with my team.

During February and March, I was spending a day or so a week in Glasgow at Yorkhill hospital. From January to March, Colin Masson would have been spending a similar amount of time in Dundee. During that period, vis-à-vis my commitment to Dundee Teaching Hospitals NHS Trust, I focused more on that year's financial performance and the closedown of that year. I was trying to deal with things that included the King's Cross hospital business case. Colin Masson concentrated more on the budgets and the forward look. There was a process of transition, double-running and trying to work together and communicate.

Scott Barrie: Were you confident that the incoming trust knew exactly which systems had been used previously and that it thought that those systems were okay? To your knowledge, did the incoming trust indicate that there was any deficiency in the systems? Did the trust indicate that information should have been communicated differently?

Mr Colville: If our systems had been deficient, in terms of either the quality of information that we produced or the accuracy of that information, our internal auditors or our external auditors would have made such a criticism known to the non-executive directors through the audit committee.

Scott Barrie: I put my next question to Mr Brown.

Were there any specific limitations in the financial management system that was used by Perth and Kinross Healthcare NHS Trust that would have contributed to the difficulties facing the new trust, to which we have alluded already?

Mr Brown: There were no such limitations that I am aware of.

Scott Barrie: I will ask you the same question that I asked Mr Colville. Did the new trust indicate to you that it felt that the information that had been provided to it was in anyway insufficient, or that it was not what it would have expected?

Mr Brown: No; the new trust did not contact me about that matter.

Scott Barrie: Are you saying that there was no contact with you on that matter, or that there was no contact with you at all?

Mr Brown: The new trust did not express to me any concerns about the management information.

I mentioned our board papers earlier. Perth and Kinross Healthcare NHS Trust probably provided

more papers than any other Tayside trust, because of its well-known historical difficulties. Our books were, in effect, open and all our information was known to all the trusts—new and old—in Tayside. There was little that was not included in that information—the position was known from December onwards. The trust board chairmen and chief executives also received our board papers, which talked about our financial position. We gave everything that we had to everybody in Tayside.

Scott Barrie: For the record, are you confident that the incoming trust knew about the financial position that it was inheriting from Perth and Kinross Healthcare NHS Trust?

Mr Brown: Yes.

The Convener: I ask Keith Raffan to lead our questions on whether it can be substantiated that poor control over staff recruitment—which was mentioned in previous evidence—was a cause of the financial deficit.

Mr Raffan: My first question on recruitment is for Mr Colville. Can you tell us briefly and clearly what systems the Dundee Teaching Hospitals NHS Trust had in place to control staff recruitment, and the potential impact of recruitment on finances and the budget?

Mr Colville: The managers in the trust had their own budgets, whether they were clinical directors who looked after the wards and theatres, or operational service managers who managed the laundry and similar areas of the hospital. Their staffing levels were clear in those budgets and they were expected to deliver on them.

From time to time when we were experiencing cost pressures—perhaps once or twice in the two and a half years that I was at the Dundee trust—we had to impose some recruitment freezing. That happened during both 1997-98 and 1998-99. However, the controls were based on the board saying to managers, "If you have problem and you need to recruit, come and talk to the board. We will talk about it openly and find a way of trying to solve the problem." We were not trying to impose draconian controls—we are talking about patient care and we had to balance that with our finances.

Mr Raffan: I would like to pursue one or two of the phrases that you used. I am not an accountant, but I found them slightly worrying. You said that you expected managers to stick to their budgets.

Mr Colville: Yes.

Mr Raffan: How would you know whether they were doing that?

Mr Colville: Every month, I received a detailed report for each budget holder. I commented earlier about the level of detail in the information that I received at Ninewells hospital compared to the equivalent reports that I receive at the Highways Agency. For one directorate, the monthly papers were about an inch thick. Those papers detailed, ward by ward and grade by grade for nursing staff, the individual budgets together with information on recruitment of full-time staff and costs. Those reports would be available to us between the 10th and 15th days of the following month. We had to be able to report at trust level to St Andrew's House by the 15th of the month.

Mr Raffan: Are you saying that you could see pretty quickly whether a problem was emerging and that you would act immediately on that?

Mr Colville: Yes.

Mr Raffan: I do not expect you to answer this question in detail, but did the system work well or did you have frequently to intervene?

Mr Colville: I will talk about 1997-98, which was my first full year with the trust. To allow time for the annual accounts, none of the trusts in Scotland is required to produce financial returns for April. When we produced the May figures in the middle of June, it was clear that an overspend was emerging. I went immediately to see Tim Brett, who was the chief executive of the trust at the time. We discussed the situation and where the problems lay. We spent a month reviewing thoroughly the May figures and working on the June figures, which more or less confirmed the problem. At that point, we were able to determine the extent of the problem and could begin to work out a recovery plan that we could implement. When we saw that there was a problem, we got on with dealing with it. One of the positive things about working in Dundee Teaching Hospitals NHS Trust was the degree of openness, which enabled me to talk to Tim Brett when I found that there was a problem. We attempted to find a solution collectively, rather than there being issues about blame and so on.

Mr Raffan: You could talk to Tim Brett and the open-door policy meant that the other departments could talk to you.

Mr Colville: Some parts of the trust were better than others were at telling us about the problem before we saw it on our radar. Occasionally, problems would appear on our radar before the departments knew about them.

Mr Raffan: Would you describe the situation as a bit hit and miss?

Mr Colville: I will give an example. The department of biochemistry was extremely proactive in relation to where its budget was going. Members of that department would come to us with ideas about ways in which the cost base

could be reduced to ensure that the department became more efficient over time. They would also let us know of things like the fact that they had to spend money on certain tests because another department had started to use a new drug. The other department might not have talked to us about that, however. In any organisation, one gets to know who is proactive and whom one will have to chase.

Mr Raffan: You said that you did not want to impose draconian systems, because that could have affected patient care. With the benefit of hindsight, however, do you think that the systems were tight enough?

Mr Colville: If we are going to talk with the benefit of hindsight, we must recognise the fact that, if a trust whose budget is getting ever tighter is expected to cope with that by making efficiency savings through salami slices year after year, that trust will get into trouble. There must be a broader strategic vision and change must be managed across the patch.

Mr Raffan: Some £2 million of the deficit that was recorded by the new trust in 1999-2000 was attributed to the cost of employing 200 staff who were recruited by the predecessor trust in the last quarter of 1998-99. I understand that a problem arose because of switches between payroll and non-payroll budgets during that year. Are you aware of that?

Mr Colville: I have to admit that I was not aware of the issue relating to those 200 staff until I was specifically asked about it. Two years on, it is difficult to comment on such a high-level indicator. I had asked for some analysis of the figure to be conducted by parts of the trust. In my letter, I have tried to highlight areas in which there may be an explanation for the 200 staff, but I was certainly not aware of whole-scale recruitment going on in Dundee Teaching Hospitals NHS Trust in the last quarter or so of its life. If there had been any recruitment, I am damned sure that I would have been aware of it, but I have highlighted some anomalies that might have contributed to the situation.

Mr Raffan: There was a fair turnover of staff, was there not?

15:15

Mr Colville: There will always be high staff turnover in a hospital, and it will be greater in some parts of a hospital than in others. In some ancillary areas, there is particularly high turnover. In the second half of that year, we were going through a phase of reasonably high nurse turnover, with nurses moving from area to area as pressures built up within the hospital.

Mr Raffan: Where budgets change during the year and there is movement from payroll to non-payroll, presumably that is readily identifiable through the mass of information that you were telling us about.

Mr Colville: I am not entirely clear what you mean by that.

Mr Raffan: I am asking whether, where budgets are changed during the year, those changes are clearly identifiable and can be seen.

Mr Colville: The budget control mechanisms are very transparent.

Mr Raffan: So the changes can be clearly seen?

Mr Colville: They should be visible, yes.

The Convener: That contributed to a £2.1 million increase in the deficit. Are you saying that those changes would be clearly identifiable, but that you did not identify them? That has caused a massive increase in the deficit. With detailed monthly reports for every budget holder, surely that should have shown up on your radar screen, or on somebody's.

Mr Colville: You are talking about 200 people. The difficulty that I have is that, because I have not been at Ninewells for a long time and have not seen any papers, I do not know which parts of the hospital you are talking about. What I have tried to say in my letter is that there were areas such as the general services tender, which was won by the in-house bid, in which vacancies could not be filled until terms and conditions were agreed. I do not know whether that is a distorting factor in the case of the 200 staff, but we inherited some 40 vacancies when that contract came in-house.

Mr Raffan: Would all that information have been available to the board of the new trust?

Mr Colville: If it were visible on the monthly financial reports, as it should have been, it would have been available for inspection.

Mr Raffan: You said that it was visible, not that it should have been, so it must have been available.

Mr Colville: Yes.

Mr Raffan: I turn to Mr Brown, for whom I have a similar question. Can you run through briefly but clearly the controls that the trust had in place to monitor staff recruitment, to ensure that money was available for staff recruitment and to monitor the potential impact on the budget?

Mr Brown: We had a very formal system in place from 1997, whereby all vacancies required the approval of the clinical director and of an executive director before they were passed on to

the personnel or human resources department. We put that more formal control mechanism in place simply because we were aware that many of our budgets were overspent.

Mr Raffan: You used the word "formal", but that word was not used by Mr Colville—not that I am trying to set you against each other. Do you think that your system was more formal than his was?

Mr Brown: I honestly do not know the systems operating in Dundee or Tayside well enough to make a comparative judgment.

Mr Colville: It is fair to say that the trusts were probably facing different types and degrees of financial pressure, and one reacts accordingly.

Mr Raffan: I come now to the vexed question of the recruitment of additional nurses, which added £300,000 to the trust's wage bill, and the suggestion that that was done without formal approval. Aside from his written evidence, I ask Mr Brown to put on record orally whether he recalls that situation.

Mr Brown: The trust did not employ additional nurses at the figure quoted to the committee.

Mr Raffan: So how do you think that the rumour developed that it did?

Mr Brown: That caused us to do a bit of searching to find out where the information may have emanated from. I have given the committee a possible source, having undertaken a little research into the budget during the last quarter of the year. It has gone up by £284,000—almost £300,000. That could have given rise to the belief that the increase was due to additional nursing staff being employed, but it was due solely to the second stage of a nursing pay award and approved waiting list moneys from Tayside Health Board.

Mr Raffan: That was funded directly by the health board?

Mr Brown: Yes.

Mr Lloyd Quinan (West of Scotland) (SNP): My questions are to Miss Ballie and Mrs Inwood and follow on directly from Mr Raffan's questioning. In your letter, Mrs Inwood, you have given us seven reasons why you were surprised at the evidence that we were given by Paul White, who cited the recruitment of nurses in Perth, which added the £300,000 to the payroll bill, as an example of the kind of developments that were allowed to happen without full recognition of their financial impact. Partly for the record and also to allow us to explore that area further, can you give us an outline of the reasons why you reject entirely Mr White's assertion?

Mrs Caroline Inwood (Former Director of Nursing, Perth and Kinross Healthcare NHS Trust): In my letter, I have tried to identify clearly that there were robust financial processes in place that would not have allowed £300,000-worth of additional nursing staff to be recruited. Those processes have already been described by Mr Brown. We had a robust system in place in which vacancies had to be approved, primarily by an executive director and a clinical director. If I were being asked to sign off such a request, I would check with finance that a funding stream was available before I approved a vacancy for recruitment.

I am aware that £300,000 probably equates to approximately 15 nurses. I can clearly remember that I did not sign off 15 additional vacancies at any one time during my time at Perth and Kinross Healthcare NHS Trust. The committee has a copy of my job description. I did not have authority to recruit without the director of finance confirming that funding was available. I was trying to demonstrate that, to my mind, there is no way that £300,000-worth of additional nursing staff can have been recruited.

The committee has had additional information from Mr Brown that identifies that, during my period in Perth and Kinross Healthcare NHS Trust, the nursing establishment decreased by 116 nurses. That does not add up with the 15 additional nursing staff, at a cost of £300,000, that it has been suggested were recruited.

I go back to Mr Brown's evidence on the waiting list initiatives. I could identify no other way in which we had spent anywhere near £300,000 on nurses. I spoke to the nurse managers who were in post at the time. I did not confine my conversations to Perth royal infirmary. I also looked at other parts of the trust, such as Murray royal hospital. The nursing managers there agreed with me. To use their words, they would have thought that it was Christmas if I had said to them that they could have 15 more nurses.

Mr Quinan: I fully appreciate that, but we have been told in previous evidence-taking sessions that the decision to employ those phantom additional nurses—I accept that I have in front of me and you have just confirmed for the committee your position on that—was taken on the basis of a telephone call between two senior nursing staff. Can you tell us whether that is the case, which I know will be repeating something that you have already stated, and whether you believe that it was possible at that time for a decision of that magnitude to be made in such a manner?

Mrs Inwood: To answer your last question first, absolutely not. I never at any time had a telephone conversation with the then chief nurse in Tayside to say that we could recruit that number of nurses. The director of finance and I—and, indeed, the chief executive—always agreed what we wanted.

We had previously prepared a manpower plan and we undertook a review of nursing staff throughout the trust in conjunction with Tayside Health Board. We agreed at that point that until the whole package was accepted, there was no way that we would implement part of any agreement. When I left Perth and Kinross Healthcare NHS Trust, there was no agreement with the board, and on that basis no additional nursing staff were employed.

Mr Quinan: Why do you think that Mr Paul White believes that the situation happened and that there was a telephone call, nurses were recruited, and the cost was £300,000?

Mrs Inwood: I cannot explain that. I know what happened while I was at Perth and Kinross Healthcare NHS Trust. I refute what is claimed to have happened. I cannot give you an explanation.

Mr Quinan: Effectively, you are saying to the committee that you are mystified as to why that assertion was made.

Mrs Inwood: Yes.

Mr Quinan: Miss Ballie, I have the same question for you, but to begin with, what is your take on the assertion that it would have been possible under your financial regime for two senior members of staff to decide during a telephone call to recruit additional nurses?

Miss Ballie: That would simply not be possible. We had a system in place between Tayside Health Board and Perth and Kinross Healthcare NHS Trust that ensured that when any new additional funding was to be made available, a document would be transferred from Tayside Health Board to the trust. That document would contain details of the funding and the number of whole-time equivalents that we could recruit for the new developments, such as the waiting list initiative. Unless that document came through and was signed by the director of finance from Tayside Health Board on behalf of the chief executive and by our chief executive, no developments were put in place.

Mr Quinan: So the finance could not be released?

Miss Ballie: It could not.

Mr Quinan: In that particular manner?

Miss Ballie: That is correct.

Mr Quinan: We have your evidence, which effectively confirms everything that Mrs Inwood has told us. I have to ask you the same question that I asked her: do you have any clue as to why Mr White made his assertion?

Miss Ballie: I simply cannot understand it on the basis of the actions taken by Perth and Kinross Healthcare NHS Trust. It does not represent the reality of what took place.

Mr Quinan: Thank you.

The Convener: We will now examine whether incoming managers should have been aware of the need for funding for developments in cancer and renal services.

Margaret Jamieson: Before we go on to that, I indicated that I wanted to ask a question. There are individuals who are not au fait with health service terminology. Nursing staff were mentioned. I take it that that covers registered and non-registered nursing staff?

Mrs Inwood: The manpower review that was undertaken looked at the whole nursing complement on each ward area. The process applied to all staff, regardless of whether they were nursing staff.

Margaret Jamieson: And whether they were registered or non-registered.

Mrs Inwood: I mean that in the recruitment process, regardless of whether they were nursing or ancillary staff, they all had to go through the same process of approval.

Margaret Jamieson: Mr Colville, £2 million of the deficit that was incurred by Tayside University Hospitals NHS Trust in 1999-2000 has been attributed to the cost of new developments for which budgets had not been approved. Can you explain how, as finance director, you would have been aware of the new developments, and what action would have been taken to ensure that appropriate funding was available?

Mr Colville: One of the most significant developments that took place in Dundee Teaching Hospitals NHS Trust, and probably in Tayside in recent years, was the investment in 1998-99 to upgrade cancer services. A significant amount of work was going on, for example, clinical networks were looking to develop services, and the three cancer professors contributed their views on how they wanted services to develop. We as managers of the trust were working with Tayside Health Board and the clinicians to try to find an agreed way forward.

We were given significant funding in 1998-99, and Professor Elaine Rankin joined in February 1999, but did not start treating patients until about June. The money that we spent on the development in 1998-99 was within the funding that we were allocated, but the spend was on a rising trend, as Elaine Rankin was building up her portfolio of patients. Problems to do with the need for additional money in 1999-2000 were signalled to Tayside Health Board in order to keep the development going; otherwise, we would have had to scale it back down.

15:30

We were debating whether the health board was to provide the additional money to allow the trajectory to carry on in the direction that Elaine Rankin and her team wanted or whether we were to slow things down and reduce the volume of treatment or the number of different new treatments that were being provided. There was a lot of involvement with managers of all species and with clinicians.

Margaret Jamieson: I have some concerns about that answer. You indicated that it took four months for that clinician to build her own portfolio. What do you mean by that?

Mr Colville: Clearly, if a new doctor, professor or whoever starts treating patients using new regimes, it will take time for the new patients to come into the outpatient setting, or for them to come through from outpatient clinics to inpatient or day-case treatment.

For the sake of argument, in the first two or three months after Professor Rankin became active, she might have been spending £20,000 or £30,000 a month in drug costs. As the number of patients she was treating grew with time, and as more new treatments were introduced, that £20,000 or £30,000 a month became £50,000 or £60,000 a month.

Margaret Jamieson: At whose discretion were the new treatments introduced?

Mr Colville: The treatments were being led by Professor Elaine Rankin, the professor of medical oncology. A lot of debate was going on with the health board—with those involved in public health medicine and with managers—and with the other cancer professionals in Dundee Teaching Hospitals NHS Trust, including the medical director, the director of nursing, the acting chief executive and with me. We were trying to plot our way forward and to agree which treatments were to be provided and funded and which were not to be provided and funded.

Margaret Jamieson: While you were doing that, what happened to the patients?

Mr Colville: While we were doing that, Elaine Rankin was increasing the portfolio of her patients, and the patients were being treated.

Margaret Jamieson: In what manner were they being treated: with the drugs or using the regime that that individual—

Mr Colville: With the new drug regimes. One of the pressures on the system was not just on the drugs bill but on pharmacists and nurses, who had to cope with the increased work load.

Margaret Jamieson: The use of those regimes was obviously viewed as a development of the service, and, according to your own statement, you were talking about the level of funding that you had for that. Meanwhile, the regime was being developed irrespective of your views or of the views of members of the health board. That clinician was clear about the direction in which she wanted to go.

Mr Colville: I do not think that it was being developed irrespective of the views of the members of the health board. The health board had committed very significant funding to developing the cancer centre, which was clearly stated as a national priority. I think that it was recognised across Tayside that, in previous years, our cancer services had been second best to those available in Edinburgh and Glasgow. There were clear needs to be addressed in that respect. Inevitably, there was a debate about how fast Elaine Rankin should be allowed to develop cancer services in Dundee and about what was affordable or not affordable.

Margaret Jamieson: Did you ever, at any time, benchmark your services against those provided in Glasgow and Edinburgh?

Mr Colville: Not formally, but Kay Fowlie, who did a lot of good work on the cancer centre and headed up the contracting and planning area, had contacts in Edinburgh. Through her we had a certain amount of information as to what was going on in Edinburgh hospitals.

Margaret Jamieson: So you allowed your service to evolve without taking account of the best practice that had already been tried and tested elsewhere in Scotland?

Mr Colville: I am not sure that one can talk about best practice in hospitals in the same way as one might for building a road or something. Cancer is a live subject. There are developments and changes all the time. As I saw it, much of a finance director's role in a trust such as Dundee Teaching Hospitals NHS Trust was to work closely with the chief executive and the medical director to understand the issues and priorities and to find the funding to meet those priorities. The situation is not black and white; it is grey and emerging and it requires frequent judgment.

Margaret Jamieson: Is there absolutely no requirement for the information statistics division—ISD—figures or for the blue book costs to be compiled with such regularity? Should individuals be allowed to just create their own service?

Mr Colville: No. Calman and Hine's work on cancer networks and Sir David Carter's work on the acute services review, which mentioned clinical networks, are fundamental to areas such as cancer care.

From time to time, I attended some of the cancer

network meetings in Tayside. I did that not because I was a member of the group, but because I wanted to understand what the diverging views were. I wanted to understand what public health medicine, our cancer professors and the other clinicians were saying on issues that were important for the trust.

The ISD figures and the cost book—the blue book, as we knew it—must be read with considerable caution because benchmarking must be about getting consistent definitions across the whole patch. Although in recent years the centre has made a lot of progress in improving the quality of information in the blue book, it is not particularly reliable.

After I left Dundee Teaching Hospitals NHS Trust, I did consultancy work for another health board. As I tried to drill down and look at efficiency performance, I found fascinating the way that certain trusts counted certain activity. In my view, parts of that health board's area were massively over-counting activity. Cost divided by over-counted activity will in that case result in a different unit cost to that of other hospitals.

Before 1 April 1998, a lot of the day surgery in general surgery in Ninewells was not counted for the purposes of the blue book. We treated such surgery as an outpatient attendance with a procedure carried out. One must be careful when one interprets the benchmarking information. The blue book is pretty crude. It is helpful, but it must be read with care.

The Convener: I know that two other members want to come in, but I would like to move on.

Two impossible pressures were working on the financial system. One was a demand for services—which was obviously patient-led. The other was the lack of money. To spend on increased patient services, money would have to be taken from somewhere else. If you saw that you were going over budget, whom did you warn that funds were not available? With whom did you raise those issues? Surely, there must have been a mechanism to allow those forces to balance out?

Mr Colville: As I said earlier, a key part of the finance director's role is building a relationship of trust with the chief executive and the medical director, so that such things can be talked through. There would be occasions on which Derek Maclean would come to us and say, "I've got this problem that's got to be fixed. This is the way it's got to be fixed and this is what it's going to cost." Tim Brett and I would, from time to time, have to say, "Okay, Derek. We agree with you. It's our job to find the money."

On occasion we were dealing with haemophiliacs, who wrote to the hospital saying that they were not prepared to accept a particular variation of blood factor VIII because it might be contaminated with HIV or whatever. They wanted us to give them another version, which is imported from America at considerable expense, or they were going to refuse treatment. The consequence of that would have been their death. In such situations, the finance director must have a relationship with the chief executive and the medical director which means that, together, they can find a sensible solution.

The Convener: Who, ultimately, makes the decision?

Mr Colville: It must be a collective decision, but the chief executive is accountable to the trust board and to St Andrew's House for the trust's performance.

Mr Raffan: I find this an extremely interesting area, but it is also tremendously complex and difficult. It is a grey area, in the sense that it involves subjective judgment all round. We want to improve cancer services and do not want to inhibit their development, but the financial impact of allowing uncontrolled development is huge. The underlying pressures are the same for new treatments and combination therapies for HIV, as you mention in your letter, and for hepatitis C. There is a complex interface between the finance director and the clinician who is in the vanguard of their particular field.

Mr Colville: You refer to the development getting out of control. We were aware of where the trajectory was leading us, as was Tayside Health Board. We were trying to work hard with Tayside Health Board and the clinicians to ensure that things would be in balance for the following year. We knew that the funding that we had for 1998-99 was sufficient for the spend that we were incurring, but we were mindful of the implications of that trajectory for the following year.

Mr McAllion: I understand what you are saying. You were aware that the trajectory was leading you towards a future deficit unless something was done about it. However, let us return to the patients who were being treated by Professor Rankin. If the money had not been available—if your hospital had closed down or cut back on services—would those patients have been transferred to other centres in Glasgow and Edinburgh for treatment, or would they have gone untreated?

Mr Colville: You would have to ask the clinicians that question. Judging from the activity levels that we experienced, and from informal conversations with clinicians, I would guess that those patients would not have been treated—they would not have been sent to Edinburgh or Glasgow. They might have received suboptimal treatment in Tayside, or they might have received

no treatment.

Mr McAllion: Was that because Tayside Health Board would have had to pay for their treatment in Glasgow or Edinburgh?

Mr Colville: If they had been referred to Edinburgh or Glasgow, the health board would have had to pay. As I said earlier, we must make difficult judgments: things are not black and white. We tried to operate the trust through partnership between managers and clinicians and to make informed choices. I do not recall the health board trying to put embargoes on the referral of cancer patients to Edinburgh and Glasgow. I suspect that the board was trying to encourage the repatriation of some patients who had previously been referred for treatment in Dundee, at a slightly lower cost than sending them to Edinburgh or Glasgow.

Mr McAllion: Were not the board and the trust also in a very difficult position? They had a lot of kudos from the significant funding to set up the cancer centre. To have cut back on that in the following year would have been a significant loss of face for all concerned.

Mr Colville: It would have been an extremely difficult issue for the trust. That is why we were working very hard to find an agreed way forward. Clearly, there were risks that, if we had pulled the plug on funding and battened the hatches right down, some professors would have left Dundee and it would have been very difficult for Dundee to recruit clinicians of that calibre in the future. There would have been a credibility problem. We were mindful of that in our dialogue with Tayside Health Board.

15:45

Mr McAllion: The Wellcome Trust came to Dundee at that time. Dundee was trying to build its image as the centre for cancer research. Would it have been very difficult to cut back on cancer services at that point?

The Convener: We are coming to the end of the session, so would you respond briefly?

Mr Colville: I do not think that the university was putting any particularly strong pressure on us to increase investment to protect its investment in cancer. It was keen—as we were—to build cancer services in Tayside so that the local population had access to the same quality of service as the populations of Glasgow and Lothian.

The Convener: This has been a very long, useful and detailed session. I would like to confirm a few things for the *Official Report*. Mr Colville, would you confirm that in April 1999 the accountable officers of the health board in two trusts knew about the financial problems that you have outlined today?

Mr Colville: I believe that they must have had a pretty good idea of the extent of the problems. Earlier, I mentioned the conversation that I had with Paul White during his interview process.

There were many meetings in January, February and March. I do not recall having a face-to-face conversation with Paul White or Colin Masson, or giving them a bit of paper that had £9 million written at the bottom of it. That conversation may or may not have taken place—I cannot recall. However, there were many meetings. Rereading some of the minutes of those meetings, which I received last night, has been interesting. In particular, the Perth issues were very openly displayed to the directors of the new trusts.

The Convener: During the interview process that led to Paul White's appointment as chief executive officer of Tayside University Hospitals NHS Trust, you said that you

"explicitly raised with him the issue of the likely deficit as I felt it was important that he view the post in the full context".

Is that correct?

Mr Colville: Yes.

The Convener: Mr Brown, would you confirm that the accountable officers of the new authorities knew of the financial situation in April 1999?

Mr Brown: Yes.

The Convener: Would you confirm that on 7 January 1999, Tayside area efficiency group's review of Perth and Kinross Healthcare NHS Trust's progress revealed an £11.3 million deficit, of which £3.3 million referred to Perth and Kinross?

Mr Brown: Yes.

The Convener: Would you confirm that Mr David Clark, the director of finance of Tayside Health Board—and therefore through him Tayside Health Board—knew that?

Mr Brown: Yes.

The Convener: Mr Colville, would you confirm that at the meeting of the council of clinical directors of Dundee Teaching Hospitals NHS Trust in September 1998, you

"predicted a deficit of £9 million for the new acute Trust".

Mr Colville: Yes.

The Convener: Would you confirm that Mr Derek Maclean, the medical director,

"put that figure into the public domain at the Annual Public Meeting in September, 1998"

and that

"this meeting was chaired by Sir William Stewart"?

Mr Colville: Yes. The only qualification is that I assume that Sir William Stewart chaired the meeting. The minutes would have to be checked, but I think that he did. Certainly, the £9 million was put into the public domain at that meeting.

The Convener: Thank you for that clarification. In September 1998, the £9 million deficit was publicly stated and we will check that Sir William Stewart—who was chairman of Dundee Teaching Hospitals NHS Trust and later chairman of the Tayside University Hospitals NHS Trust—chaired that meeting. Did Mr Paul White, the chief executive-designate of Tayside NHS trust, know of the financial situation?

Mr Colville: Of the £9 million?

The Convener: Yes.

Mr Colville: I do not know whether he was at that meeting. I cannot recall when the chief executive appointments were made, but there must be evidence to clarify that and whether he was present at that meeting.

The Convener: I thank the four witnesses for attending and for their evidence. The session has been quite long.

Mr Peter Bates (NHS Tayside): With your agreement, I would like to make some points. I am happy to make them now, or at the end of the meeting.

The Convener: You can make them at the end of the meeting, if you do not mind.

There will be a ten-minute adjournment to allow the next witnesses to be seated and to adjust the microphone levels.

15:49

Meeting adjourned.

15:59

On resuming—

The Convener: I welcome our two further witnesses. You have both been patient, which we appreciate.

I want to ask Mr White and Mr Brett about the potential for a financial deficit at Tayside University Hospitals NHS Trust. In your evidence at our meeting in Dundee, you both said that you were shocked to discover the extent to which previous trusts relied on non-recurring expenditure. We have now heard evidence from two of the earlier trusts that suggests that you were aware before the year began that the TUHT was forecasting a significant deficit and that a robust recovery plan to eliminate Perth and Kinross trust's deficit was in place. In those circumstances, why were you so surprised?

Mr Paul White (Tayside University Hospitals NHS Trust): I made it clear in my earlier evidence that we were aware of the Perth and Kinross situation. It was transparent when the new trust was formed. There was also a recovery plan. We were involved in discussions about the plan and a range of measures were set out in it. Mr Frank Brown and Miss Pamela Ballie said in their evidence that several elements of the recovery plan did not come to fruition—one being the £500,000 that was attributed to implementation of the acute services review, which has not yet happened.

It was not possible to implement other elements of the recovery plan or they were implemented at a slower pace. One example was the attribution of £50,000 as income against an education centre at Perth royal infirmary. The centre did not produce any income. We inherited a scheme to introduce car-parking charges, but little work had been done on it. The work on the scheme had to be built up by the new trust. Several months passed before income was attributed to that scheme. Some elements of the recovery plan produced no savings, while others did but at a slower pace than was expected.

We were aware of several financial problems at Dundee Teaching Hospitals NHS Trust, but we were not aware of their sheer magnitude—that was not apparent. Earlier, Philip Colville said that he could not recall whether he had given an impression of £4 million to £9 million, £10 million or £11 million. We were not aware that there was a genuine £9 million problem.

To underscore that comment, I refer the committee to some papers that have been submitted, such as the letter dated 16 February 1999 from Tim Brett to Paul Brady, who was then the director of finance at the management executive. In the paper that was prepared collectively by the Tayside health bodies there is an indication of the need to make efficiency savings of £4.6 million throughout all four Tayside trusts. The paper showed that that would produce a savings level of £3.2 million in the year 1999-2000. That same paper showed developments and cost pressures to the tune of £7.4 million, but in no way did it state that there were additional cost pressures of £6 million to £7 million.

The Convener: The deficit was about £9 million. You say that all those efficiency savings did not materialise, a problem that showed up later in the Auditor General's report, but we are also told that a constant stream of detailed information was available to you from Perth and Kinross Healthcare NHS Trust and, indeed, from Dundee Teaching Hospitals NHS Trust. Perth and Kinross Healthcare NHS Trust has told us that there were minutes of board meetings and other information.

Where was the surprise?

Paul White: I did not receive copies of board minutes. The position in Perth and Kinross was not a surprise; it was transparent—I made that clear when I gave evidence last time. The particular problem was probably somewhat greater than was expected. The genuine problem that was apparent with the Dundee element of the financial pressures was not made clear during the shadow period.

The Convener: It was not made clear during the shadow period.

Paul White: Not the magnitude—not that there was a problem to the tune of £9 million to £10 million.

The Convener: But you knew that there was going to be a deficit, so what figure did you have in mind?

Paul White: Almost every health trust in the country faces financial and cost pressures. That happened when I was in Fife; it happens up and down the country. However, the magnitude of the problem, and the extent to which non-recurring funding was underpinning recurring costs, were most certainly not evident.

The Convener: I find it strange that, on 16 February, you signed off the Tayside-wide financial framework for 1999-2000. That plan was submitted to the director of finance at the management executive by the chief executive of Tayside Health Board. It was signed off by you and by the other two chief executives. In September 1998, you were told by Mr Colville about the £9 million. He said that the information was in the public domain. He explicitly said to us that, from October 1998, when you were 50 per cent in your new post, you were fully briefed when you attended meetings of the previous trust. Is that true or not true?

Paul White: I would like to make a number of points in response to that. During the shadow period, in no way did I spend 50 per cent of my time in Tayside. Philip Colville himself cited the example of his being appointed to the Yorkhill NHS Trust while he was in Tayside. He said that, on average, he spent about a day a week in Yorkhill. I spent about the same amount of time in Tayside. I was the full-time accountable officer for a Fife trust up until 31 March 1999. My prime responsibility during that time was to deliver on the accountabilities for which I was responsible to that Fife trust, right up until midnight on 31 March 1999. I was not freed from those duties. The impression seems to have been created that I somehow had the opportunity to spend a lot of time in Tayside during the shadow period; I did not. I spent as much time there as I could, but my prime responsibility was to the trust that I was running and that I was held accountable for, in Fife. I spent some time—probably, on average, about a day a week, increasing to a couple of days a week—in Tayside as the start of the new trust came closer. The first meeting of the shadow board did not take place until 9 February 1999—less than two months before the new trust came into effect.

The Convener: Were you alerted to the deficit in your interview, as Mr Colville has suggested?

Paul White: Mr Colville was not on my interview panel. What happened in the process for—

The Convener: I am sorry—but he said that, before you took up your new post, he alerted you to the problem.

Paul White: I think that the record will show that, when questioned more closely, he indicated that he could not recall having mentioned the figure of £9 million. He certainly did not mention it. If Philip had mentioned a figure of that magnitude to me, I would have recalled it. He may, during the course of a presentation that I made to about 30 or 40 senior managers and clinicians in Ninewells hospital, have made a general comment about how I might address a position of financial problems in the new trust. That would have been one comment in a wide range of comments from a wide range of clinicians who were asking me for various reactions and responses. Sir Alfred Cuschieri was in the audience, as were many others from the clinical staff at Ninewells. There may have been one comment, but it was not specific about the figure.

The Convener: You were joining an authority that had had financial problems in the past. Did that not alert you to the need to search out possible problems—which turned out to be very large problems? Were you not alerted to potential problems?

Paul White: I can provide the committee with a copy of a letter that I wrote during the shadow period to all four chief executives of the demitting trusts, asking for their help and co-operation, and the help and co-operation of their staff, to make efficiency savings during the year.

The committee heard evidence from Perth and Kinross Healthcare NHS Trust that it had put in place a recovery plan for a deficit that was of a much lower magnitude than that which transpired in Dundee. There was no sign of a recovery plan of a similar nature for Dundee and there was no evidence of reports going to the Dundee Teaching Hospitals NHS Trust board during the last six months of its period of office that indicated anything like a £9 million deficit. The recovery plan that was submitted to Tayside Health Board on 25 March 1999, six days before the new trust started, indicated a requirement for Tayside to make

efficiency savings of £5.2 million. Of that £5.2 million, the acute trust was responsible for £2.8 million. There is a major difference between that and the magnitude of the figures to which Philip Colville alluded. Tayside University Hospitals NHS Trust made efficiency savings of £3.1 million in its first year—we exceeded the £2.8 million target that was set. Despite that, we still had a significant deficit at the end of the year.

The Convener: I find it a contradiction that we are told that there was a constant stream of information, that people were informed, that information was noted in board minutes and that problems were flagged up, but you—the incoming chief executive officer—say that you were not aware of the problems.

Mr White: What I am saying is—

The Convener: Sorry—what did you know about the deficit? You were surprised by the Dundee deficit, but not by the Perth and Kinross one.

Mr White: Yes. I have not changed the evidence and I stick by what I said. I was surprised by the magnitude of the deficit that we inherited. The Perth and Kinross position was clear. I said that last time, I still say that and I agree with the evidence that Frank Brown gave. What was not clear was the scale of the problem in Dundee and the extent to which non-recurring funding was supporting recurring costs. That is picked up in the Auditor General's report and was picked up by the task force. I think I am right in telling members that, if they look at the minutes of the Dundee Teaching Hospitals NHS Trust board during the latter part of its time, they will not see reference to a problem of such magnitude.

The Convener: When did the extent of the problem become clear to you and what inquiries did you make leading up to that point?

Mr White: As I said previously, it became clear at the end of the first quarter of the new trust that there was a very major financial problem. During the analysis of that, other factors emerged and some of the internal correspondence of Dundee Teaching Hospitals NHS Trust from 1998 became evident, but that was not until after the new trust started.

The Convener: I know that my colleagues on the committee wish to come in at this point, but before inviting them to do so, I will put the same question to Mr Brett. Why were you surprised at the extent of the deficit?

Mr Tim Brett (Tayside Health Board): Because I was not aware of it when I first went to the board in January 1998 and because Perth and Kinross Healthcare NHS Trust had met its financial targets in the previous year. I cite the fact that, in January 1998, the trust indicated that it had a problem of only £100,000, although I readily admit that, in the preparations for the following year's budgets, the trusts were signalling that they had a much larger recurring problem. It was not until later in 1998 that we and the trusts agreed to send in our own finance staff and that the full extent of the problem became apparent.

The Convener: We were told by Mr Waldner:

"I had no formal reporting relationship with Tayside Health Board. Both I and the rest of our team worked very closely and collaboratively with officials at Tayside Health Board, and indeed, due to the fact that my direct supervisor, and substantive Chief Executive, was acting up in the Chief Executive role at Tayside Health Board, we were able to ensure that the Board were kept fully appraised of the key issues facing our Trust."

If a large deficit is not a key issue, what is?

Mr Brett: It might be helpful if I explain to you and to the rest of the committee how we went about preparing the—

The Convener: I am anxious to find out whether you knew the extent of the deficit. If not, why not? According to Mr Waldner, you were kept fully apprised.

Mr Brett: I was not aware of the deficit in 1998-99, but I am happy to set out for you the basis on which we developed the financial framework for the following year.

The Convener: When did you find out the extent of the deficit? Mr David Clark, director of finance at Tayside Health Board, produced on 7 January 1999 a figure of £11 million for the deficit. He did not produce that out of nowhere.

16:15

Mr Brett: No. Convener, if you would allow me to explain our position in that year, it would be helpful for the committee's understanding.

In October 1998, David Clark, as he has done since, produced a paper for the health board, setting out the initial financial position for the following year. He indicated that there were a range of financial pressures of which we were aware. Shortly after that, Perth and Kinross Healthcare NHS Trust's position became clear. We worked jointly with the existing and incoming chief executives to deal with that position and that led to the production of the recovery plan the following February. As part of that process, David Clark had meetings with all four of the then trust finance directors and discussed with them what the pressures were. That led to the figure that you have just quoted, convener. We were aware of that, but I would also agree with Paul White that financial pressures were being flagged up in every financial year around the time.

The Convener: But you were the accountable officer and the problems were developing. According to evidence given to us, the trust board was to be kept fully informed of all matters of relevance and importance and minutes were available—yet you did not know that the problems were developing.

Mr Brett: Let me go on. From early 1999, we worked together to develop the financial framework for the following year. In March of that year, there was a joint meeting between the financial directors and the three chief executives, which set out clearly the financial pressures that we were facing. The pressures at that time were some £12 million.

The Convener: The director of finance gave regular progress reports to the trust board and the board was kept fully informed of all matters of relevance and importance. Clearly, a major problem was building up and it seems strange that the person responsible for accounting for that learned of it rather late. Why was that?

Mr Brett: I am sorry, convener, but I do not think that I was accountable for the trust's financial performance—as you are aware—

The Convener: No, but you are accountable to the central Government for its financial performance and I would have thought that, given that information was coming to you, you would have taken it into account in your dealings—for example, by informing central Government that a major problem was brewing. I am anxious to find out what you knew and when you knew it.

Mr Brett: We certainly did take that into account. We flagged the matter up as part of the jointly submitted recovery plan in February. In March, we jointly prepared the financial framework, which was subsequently submitted to the health board in April. We were aware of financial pressures—of which I have a list—from all four of the predecessor trusts.

I will outline the difficulties that we faced. First, as part of the settlement, we agreed to fund fully, or nearly fully, the Perth and Kinross deficit, which put greater pressure on the rest of the Tayside service. All four trusts met their financial targets, so a great deal of the financial pressures were being managed successfully by the trusts. We were explicit about those and have lists of what they were. In the paper that was sent to the board, it was acknowledged that there was a challenging efficiency savings target of about £5.2 million; it was also publicly acknowledged in that paper that there were other pressures, which the new trusts would need to manage.

The Convener: But the budgets were met through non-recurring expenditure and unachieved financial savings. In February, you told the health department that all was well, yet two months later, all was obviously not well. I do not understand how such a deficit could arise and how the department could not be told about it in February, yet could be told two months later that there was a deficit of £9 million or £12 million.

Mr Brett: It was not a deficit at that point. That was part of our preparation of the estimates for the following year. It was based on the regular pattern of meetings with the trust finance directors and those finance directors pulling that together.

Mr Raffan: I shall be brief, as we seem to be flogging a dead horse. There seems to be a clear contradiction between what you say, Mr White, and what Mr Colville says. In his letter, having just mentioned the £9 million in the previous sentence, Mr Colville says:

> "During the interview process that led to Paul White's appointment as Chief Executive I explicitly raised with him the issue of the likely deficit".

I am not saying that you are sheltering behind the question of whether Mr Colville did or did not mention the £9 million to you. However, the *Official Report* will show that he explicitly mentioned the scale of the deficit. You are saying that that is not so.

Mr White: I listened carefully to Mr Colville's evidence, and the *Official Report* will show that he mentioned a range of between £4 million and £11 million and said that he could not recall whether he had mentioned to me a figure of the magnitude of £9 million to £10 million.

Mr Raffan: His letter says that he raised the matter with you specifically during the interview process. He says that he cannot remember the exact date of your interview, but that he raised the matter with you on that date, prior to your appointment.

Mr White: That is what he says in his letter. In his oral evidence, when he was pressed several times, he said that he could not recall mentioning that figure to me. I am saying to you that I have no recollection of Philip Colville mentioning to me a figure of the magnitude of £9 million. Had he done so, I would certainly have picked up on it. Furthermore, in support of the evidence that I have just given, I cite the fact that the management executive was not aware of that magnitude of problem—nor was the health board, as you have just heard. I would have thought that, if there was concern about that level of deficit, the matter would have been raised at the board meeting of Dundee Teaching Hospitals NHS Trust, with the health board and with the management executive.

Mr McAllion: According to Mr Colville, it was Dr Derek Maclean who put the figure of a £9 million deficit into the public domain at a meeting of the clinical directors in September 1998. What is Dr

Derek Maclean's official title and what was it then?

Mr White: Derek Maclean was the medical director for Dundee Teaching Hospitals NHS Trust.

Mr McAllion: Is it fair to say that he was one of your closest colleagues when you were appointed as shadow chief executive and then chief executive?

Mr White: Yes, Derek was one of the executive directors.

Mr McAllion: Are you trying to tell the committee that, between September 1998 or the time of your appointment and the time that you took over in April 1999, he never mentioned to you the figure of a £9 million deficit, which he had put into the public domain?

Mr White: Derek made reference to a range of cost pressures, some of which exceeded that level. On a number of occasions, he made reference to the fact that there might be significant cost pressures on services.

Mr McAllion: Did he ever mention the figure of £9 million to you in the period to the end of March 1999?

Mr White: Derek mentioned possible problems, which could run up to £20 million—that was a figure that he mentioned at one stage.

Mr McAllion: It is hard to believe that he found it necessary to tell the clinical directors at Dundee Teaching Hospitals NHS Trust that there was a £9 million deficit in the pipeline but did not tell the new chief executive, who took over in the following April, of that possible £9 million deficit.

Mr White: Derek Maclean often talked about issues that came across his desk. There was a range of potential service developments—new drugs and new treatments—that, if implemented, would have incurred a deficit even beyond the £9 million.

Mr McAllion: How can you tell the committee, as you did in Dundee, that you were shocked to discover that there was a £9 million deficit if your medical director told you that the deficit might be as much as £20 million?

Mr White: The financial information that was available to us did not show that. I reiterate what I said earlier: if that magnitude of problem was genuinely felt to be a possibility, it should have been reported to Dundee Teaching Hospitals NHS Trust.

Mr McAllion: Your medical director told you that there might be such a problem.

Mr White: The responsible body at that time was the board of Dundee Teaching Hospitals NHS Trust, and there is no evidence to show that a figure of that magnitude was reported to it. As chief executive, one receives information from many different sources, and the prime responsibility for reporting financial information lies with the finance director.

Mr McAllion: If your medical director tells you about such a problem, do you not check the facts with your director of finance and ask for detailed monthly reports?

Mr White: The financial reports that were available to the board of Dundee Teaching Hospitals NHS Trust did not indicate a problem of that magnitude, nor did the recovery plan. The monthly financial monitoring returns that the management executive receives did not indicate that level of problem. Therefore, we were faced only with hearsay.

Mr McAllion: It is hardly hearsay when your medical director advises you of a problem.

Mr White: The medical director would have been acting on information that he had gleaned from the director of finance.

Mr McAllion: That is not hearsay.

Mr White: If the director of finance felt that there was a genuine problem, his prime responsibility would have been to report that to the trust board and to ensure that the monitoring returns that are submitted monthly to the management executive indicated a possible deficit of that magnitude. That is exactly how we dealt with the problem when we found out about it in the new trust. There was regular reporting to the trust board, the matter was included in the monitoring reports and the health board was made aware of it. Those three bodies were obviously not previously aware of the scale of the problem that later emerged.

Mr McAllion: So the director of finance told the medical director, who told a meeting of the clinical directors, that there was a possible £9 million deficit, but no one bothered to inform anyone of it officially. Is that what you are telling us?

Mr White: I did not learn about that meeting of the clinical directors until well into 1999.

Mr McAllion: Who was in charge then? Anybody?

Mr White: The chief executive of the trust was Howard Waldner.

Shona Robison: When did Derek Maclean give you the information about the cost pressures and his concerns, which you describe as hearsay? Was it from September 1998 onwards?

Mr White: I could not say exactly.

Shona Robison: Was it from an early stage of

your involvement?

Mr White: It would have been at some point during my time as shadow chief executive.

Shona Robison: Essentially, you are saying that you did not believe him because the problem did not show up in the paperwork.

Mr White: The paperwork did not support the possibility of such a problem. Derek tended to elaborate extensively on problems.

Shona Robison: But he was right.

Mr White: Yes, he was right.

Shona Robison: He was right, but neither you nor anyone else believed him.

Mr White: You must bear in mind the fact that, during my period as shadow chief executive, I was not in Tayside. The chief executive, the director of finance and the trust board were in Dundee; I did not take on any responsibility for Dundee until the beginning of April 1999.

What I had to do—and what the incoming director of finance had to do—was to sit down with the finance teams of the demitting trusts to reach an understanding of the actual position, through the formal financial reporting frameworks. That was the basis of our subsequent actions. The financial reports that were extant in each of the trusts were the official audited records that formed the annual accounts of each of those bodies. I do not think it unreasonable for me, as the incoming chief executive, to have relied on those financial reporting systems.

Shona Robison: They were clearly wrong.

Mr White: They did not show the magnitude of the problem that later emerged.

Shona Robison: Who else did Derek Maclean speak to at the time? He was not telling only you about the problems that he was forecasting.

Mr White: I understand that the issue may have been raised with the board of Dundee Teaching Hospitals NHS Trust. Sir William Stewart was the chairman of that board and he would be able to help with that inquiry. I cannot say.

Margaret Jamieson: You say that you were not aware of the magnitude of the financial difficulty. The accounts would obviously have been subject to internal and external audit. However, I understand that those audits did not show up the problem. Is that correct?

Mr White: The internal and external audits of the 1998-99 accounts would not have been completed until June 1999—around the same time that the reporting mechanisms for the trust were showing the problem. We touched on this issue at the committee's meeting in Dundee—I am on record as saying that it would not be reasonable to expect the auditors, either internal or external, to have picked up on the fact that non-recurring funding was being used to support recurring costs.

Margaret Jamieson: Why do you make that statement?

Mr White: I say that because much of the income to trusts is not hypothecated, so the aggregate of income is depended on to underpin the budget in the organisation. At the committee's meeting on 2 April, it was said that the budgets on which many managers relied did not have enough income to support apparently funded establishments within elements of the organisations, for example.

Margaret Jamieson: Are you saying that either the internal or external audit process was not robust enough?

Mr White: No. Others who are present today may be much more able than me to speak about audit. The purpose of the audit is to show that the accounts present a true and fair view of the organisation. It is evident that the mechanism for flagging up the use of non-recurring funding or the true potential costs of developments may not be as explicit as it needs to be.

16:30

Margaret Jamieson: Surely a process exists. It would not have been the first time that trusts or health boards have had a qualified audit, which draws attention to some issues in the audit, but that did not happen in this case.

Mr White: I am getting into territory with which I am not entirely au fait. The audit on the four Tayside trusts reported on a set of accounts that related to a time before I came to Tayside.

What I can tell you about the audit of the accounts for the first year of the new Tayside University Hospitals NHS Trust is that we made explicit—and I made explicit in the statement that I must sign off—the problems that the trust faced and would face. The external auditor corroborated that in his commentary. The accounts for the first period of the new trust—I am more familiar with them—gave a fair account of the problems that we inherited, what we had done to try to address those problems and a look ahead to the way in which we would need to address their resolution.

The Convener: We will move on to discuss the extent to which management information available to new trust managers was sufficiently robust.

Paul Martin (Glasgow Springburn) (Lab): Mr White, you explained that the full extent of the financial difficulties came to light as a result of disaggregating information from the previous trusts. Will you specify the difficulties that you

faced during that period in disaggregating that information? Perhaps you could give examples.

Mr White: I will try, but my director of finance, who has not been called to give evidence, would be much better able to give examples. The disaggregation issue pertained largely to two of the four Tayside trusts—Perth and Kinross Healthcare NHS Trust and Angus NHS Trust—as they were what were known as integrated trusts. Those trusts were split between the new primary care trust in Tayside and the university hospital trust.

Several budgets were clear and easy to apportion to one of the new bodies, but several budgets for services had been split between the two previous trusts. When a budget required to be split or a member of staff had duties in the community services as well as in the hospital services—there were several examples of those—the funds attributable to such a post had to be apportioned against each organisation. The multiple permutations or multiple exercises of running that process through all the posts in the organisation and various other budget heads took time. That is the disaggregation process to which I referred.

Paul Martin: Are those difficulties that related to aspects of the separate trusts the only ones that you experienced?

Mr White: When we discovered the size of the financial problem with Dundee teaching hospitals, we needed to understand the extent to which budgets in the organisation could and were underpinned by recurring income. When it was clear that a shortfall existed, we had to assess how to apportion that shortfall across all the budgets equitably.

Paul Martin: So you could say that you were satisfied with the information, apart from that point.

Mr White: The accuracy of the accounts and the systems that were in place were helpful. The fact that we could show within the first quarter of the new trust's existence that there was a significant financial problem indicates that the systems could show up a problem on such a scale.

Paul Martin: How did you involve the senior finance staff in that process in setting the budgets for 1999-2000?

Mr White: The director of finance would have involved them closely.

The Convener: Did you involve managers from previous trusts in that process?

Mr White: Yes, because many of those managers moved into the new trust and so would have been involved in an iterative process of discussing the services and the budgets that were required to run it.

Paul Martin: Were you not concerned, or did you not signal to any of the trusts, that some of the information with which you had been provided was inadequate?

Mr White: There was no issue about the accounts being inaccurate, although I say that subject to checking it with my director of finance. As the Auditor General's report and the task force's report say, the problem was the extent to which services were started off during the latter part of 1998-99 and the full-year effect of them hitting the new trust without the necessary income. The vacancy factor in Dundee teaching hospitals was also an element. The funding that would have paid for salaries was supporting non-pay costs. The task force picked up on 200 vacant posts whose funding was supporting non-pay costs.

The Convener: Did I catch you right? Did you say that many of the managers who built up the budgets for 1999-2000 were involved in budgeting in previous trusts and would therefore be well aware of the problems?

Mr White: The managers were involved. I am unsure how aware they would have been of the corporate problem for the trust, because their view would have been of their part of the organisation, whether it was surgery, medicine or something else. You will recall that I said that the budgets on which several managers were working would have given a false impression of the resource that was available to underpin services.

The Convener: However, if a manager came from a previous trust that had a budget deficit and all sorts of problems and moved to a new authority that partly comprised the previous trust, would not that give them cause to worry, be alarmed or investigate more closely and earlier into possible continuing budget deficits?

Mr White: The managers had been involved in preparing a range of efficiency-saving measures to roll into 1999-2000. As far as they were concerned, they were contributing their share—or what they were asked to contribute—towards the overall picture. The difficulty was that the corporate picture was not properly recognised and so neither was the scale of the problem.

The Convener: We will move on to consider whether the examples of poor control over staff recruitment, which were mentioned in earlier evidence as a cause of the financial deficit, can be substantiated.

Mr Raffan: I will raise two issues. Mr White will remember from the evidence that Mr Brett gave on 2 April that 200 staff were recruited in Dundee during the last quarter of 1998 in the mistaken belief that funding was available. That is the first

issue. We have heard that evidence contradicted today, so I would like a response on that point.

The second issue relates to the so-called recruitment of nurses in Perth, which added £300,000 to the payroll bill. Miss Ballie and Mrs Inwood directly contradicted that today. I think that the phrase used was that it did not represent the reality of the situation.

Mr White: Would you like me to respond first to the point about the staff in Dundee?

Mr Raffan: That is the issue that I raised first.

Mr White: Exhibit 11 on page 29 of the Auditor General's report indicates that £2.1 million was attributed to the vacancy factor savings released by Dundee Teaching Hospitals NHS Trust during 1998-99. That vacancy factor was released—or lost, as the report says—because the posts that had been held vacant were filled during the last quarter of the life of the trust, which was the spring of 1999. That meant that the full-year effect of those salaries was £2.1 million, a sum that was not available to the incoming trust to support the costs that those vacancies had supported in the previous year.

Mr Raffan: That has been directly contradicted, in the sense that there was no special exercise other than the usual turnover in staff. There was no special recruitment exercise.

Mr White: That is the point. The vacancies were not new posts that were created. As far as the budget managers were concerned, the posts were funded within the budgets that they held for staffing. It was apparent that the savings on those pay costs due to the posts not being filled was being used in aggregate within the trust to underpin non-recurring costs.

Mr Raffan: Before we move on to deal with the recruitment of nurses, would Mr Brett like to respond on that point?

Mr Brett: I am not in a position to comment. The health board did not receive information on the filling of posts by the trust.

Mr Raffan: Mr White, would you comment on the recruitment of nurses in Perth?

Mr White: I would like to make an introductory comment first. In my evidence, I did not say that there had been a telephone conversation between the director of nursing services and the director of planning. The *Official Report* shows that I said that the then director of nursing services

"had an understanding with the then planning director of Tayside Health Board".—[*Official Report*, *Audit Committee*, 2 April 2001; c 597.]

I said that in response to a request from Mr McAllion to give an example of a point at which costs were incurred without there being funding to support them. That example was in my mind because, when we performed an analysis of the nurse staffing levels in Perth and Kinross, the nursing staff in post were 24.05 whole-time equivalents more than the funded establishment that we inherited when the new trust came into being.

There was also an exchange of correspondence between the director of nursing in Perth and Kinross and the director of planning at Tayside Health Board. On 28 April 1998, Jeanette Macmillan wrote to Caroline Inwood saying, with regard to surgical, orthopaedic and medical nursing posts, that she would consider allocation of funding subject to discussions with David Clark. She goes on to say that

"it is clear that a number of 'creeping' developments … had a detrimental effect"

on nurse staffing and that that was

"quite unsatisfactory".

A letter dated 24 February 1999, from David Clark to Paul Brady, says, under the heading of nurse staffing, that Perth and Kinross Healthcare NHS Trust

"has factored in assumed income from Tayside Health Board of £0.380 million to support nurse staffing levels".

It also says:

"For the sake of clarity the Board will not separately fund the £0.380 million previously assumed by the Trust."

The Convener: Can we get copies of those letters?

Mr White: Yes.

That correspondence was sent before I came to Tayside, but I was aware of its existence. I was told that there had been such discussions about nurse staffing in Perth. On 2 April, I said to the committee:

"I am getting into a matter on which I do not have the exact details. I hesitate to say that I was not there."—[*Official Report*, *Audit Committee*, 2 April 2001; c 597.]

Mr Raffan: Mr Brett, have you anything to add to that?

16:45

Mr Brett: My answers at the 2 April committee meeting were based on the understanding of the situation that I had gained from going to the board in 1998. I refer members to one of the documents that Frank Brown has sent to the committee—it is in appendix 3 of the documentation before you. It deals with the recovery plan that was sent to Paul Brady in December 1998. The document talks about higher dependency levels and a cost impact of £686,000, predominantly relating to nursing

staff. I was aware of that and had assumed that part of the problem in relation to the recurring deficit of £3.3 million that Perth and Kinross Healthcare NHS Trust was facing was due to pressures on nursing staff. I may have incorrectly assumed that the trust had recruited additional staff, but staffing was clearly part of its difficulties.

Jeanette Macmillan, the board's chief nursing adviser, and the director of planning engaged in a good deal of discussion about the issue. I understood that, as Mrs Inwood indicated earlier, there were areas of pressure but that Jeanette Macmillan believed that the trust could make savings in other areas.

Mr Quinan: Both of you have described how 200 staff were recruited by Dundee Teaching Hospitals NHS Trust during the last quarter of 1998-99. Mr Brett, you said that those people were recruited

"in the mistaken belief that there was funding for them"—[*Official Report*, *Audit Committee*, 2 April 2001; c 604.]

although the money to meet those costs had already been allocated to other budgets. Who made those decisions and why did you think that someone had made that decision based on a mistaken belief? How can someone have a mistaken belief about the recruitment of 200 people?

Mr Brett: I am not sure that I can answer that, as I was not involved in the trust at the time.

Mr Quinan: You made the comment that I just quoted, which means that you are in a position to comment.

Mr Brett: Perhaps, as Mr White has indicated, the budget holders at the time assumed that funding was available. However, we have heard today from Mr Colville that there were controls in place within the trust that should have prevented that assumption from being made. I am sorry but, because I was not involved with the trust at that time, I cannot give you a more detailed answer.

Mr Quinan: My question is straightforward. You made that statement. How could you come to that conclusion and on what information did you base that statement?

Mr Brett: Can you remind me of the point in the committee at which I made that statement?

Mr Quinan: You can find it in column 604 of the *Official Report* of the Audit Committee meeting of 2 April.

Mr Brett: Having just reacquainted myself with that part of the meeting, all I can say is that that statement was based on my assumption of what might have been the explanation.

Mr Quinan: Do you accept that, effectively, you were blaming unnamed people by making that statement?

Mr Brett: No.

Mr Quinan: You said that there was recruitment under a "mistaken belief". I suggest that that was an indictment of the people who took that decision—you made that indictment, supported by Mr White.

Mr Brett: Based on the Auditor General's report—

Mr Quinan: I am referring to your comments, Mr Brett, not to the Auditor General's report. What made you believe that someone—unnamed in your remarks—was under the mistaken belief that they could recruit 200 people and that there would be a budget for that? What makes you believe that that happened?

Mr Brett: I cannot give you any direct evidence.

Mr Quinan: Can you give me a reason why you made that statement?

Mr Brett: I was making the assumption that there had been difficulties in recruitment. My understanding is that there may have been problems with nurse staffing recruitment in certain areas of the trust, perhaps to do with when nursing schools were coming out—

Mr Quinan: I do not understand how that refers to a mistaken belief within the management structure of the trust that would allow it to employ 200 people—you have completely lost me there. Do you accept that your remarks are an indictment of unnamed others and are you prepared to withdraw them?

Mr Brett: I do not have any evidence to substantiate that. As I said, that was my understanding. I was not in the trust at that time. I was surmising that that was the case.

Mr Quinan: Are you prepared to withdraw those remarks?

Mr Brett: Yes. I have no evidence to say that.

Mr Quinan: Would you apologise to those people whose reputations you have tarnished by that statement?

Mr Brett: I would if any offence has been taken.

Mr Quinan: Mr White, what is your position on that statement?

Mr White: The evidence on which it is based is contained within the Auditor General's report. The ministerial task force carried out an analysis of the increase in staff in post during the last quarter of the existence of Dundee Teaching Hospitals NHS Trust. Those staffing costs were deemed to equate to about £2.1 million of salary in a full year.

That is a fact. That recruitment took place. I would not point the finger of blame at individual managers for recruiting to posts for which they understood there to be funding in their budget.

Mr Quinan: Do you have evidence that you could provide to the committee to support the assertion that those people believed that the budget was available, or would you withdraw the remarks and apologise to those people whose reputations you have tarnished, as Mr Brett did?

Mr White: We need to be clear. We are talking about an aggregate position for Dundee Teaching Hospitals NHS Trust.

Mr Quinan: Actually, we are talking about an assertion that you and Mr Brett made.

Mr White: I do not withdraw the assertion because I am basing it on the fact that the Auditor General's report and the analysis carried out by the task force show that 200 additional posts were recruited into Dundee Teaching Hospitals NHS Trust during the last quarter of 1998-99. Those posts accounted for £2.1 million of pay costs that hit the new trust during the financial year 1999-2000.

Mr Quinan: At the meeting in Dundee, when Mr McAllion asked about the failures in Perth and Kinross, you mentioned the example of £300,000 spent on nurse recruitment. In that statement you also said that such developments were allowed to happen without full recognition of their financial impact. I suggest that that is also an indictment of the professional reputation of those who were in charge at the time. Would you withdraw that remark?

Mr White: Could you give me a column reference?

Mr Quinan: It is column 597 of the *Official Report* of the Audit Committee of 2 April.

Mr White: What statement are you asking me to withdraw?

Mr Quinan: Your assertion that the recruitment of nurses in Perth, which added £300,000 to the payroll bill, was an example of the kind of developments which were allowed to happen without full recognition of their financial impact. That statement was rejected by the people involved. Are you prepared to withdraw that remark? It is an indictment of the professional reputation of the people who were in charge of Perth and Kinross Healthcare NHS Trust, who reject your assertion entirely.

Mr White: I have presented the evidence that we had that the new trust inherited 24.05 whole-time-equivalent nursing staff in excess of the funded budget—that is an accurate figure. Those staff must have been recruited at some point and they were incurring pay costs in excess of the funding in the pay budget. That, together with the other correspondence that I cited, is the basis on which I presented my impression to the committee.

Mr Quinan: So who failed to recognise the financial impact?

Mr White: I am not saying that the financial impact was not recognised.

Mr Quinan: Is not that exactly what you said? You said that developments were allowed to happen without full recognition of their financial impact.

Mr White: That is recognition in the sense of funding being made available to pay for the costs. Perth and Kinross Healthcare NHS Trust had identified the excess cost over funding—that was part of the financial pressures that they had identified—but the additional staff that had been put in post were not recognised in the sense that funding was not made available to support them.

The Convener: As the Auditor General's report has been mentioned, perhaps the Auditor General wishes to comment.

Mr Robert Black (Auditor General for Scotland): It might be helpful for the committee if I give my understanding of the position with regard to the vacancy factor issue in Dundee. In exhibit 11, on page 29 of my report, I summarise the task force's analysis of the factors that led to the shortfall. The first of those is

"Vacancy factor savings released by Dundee Teaching Hospitals NHS Trust during 1998/99",

which was £2.1 million. That is borne out by the appointed auditor of Tayside University Hospitals NHS Trust's final report for that financial year, which says:

"in previous years, established posts were left vacant in order to help fund non pay costs. However, this practice was discontinued in the last quarter of 1998/99. The full year effect of filling theses vacancies added approximately £2.1 M to the Trust's deficit".

It is quite clear that, in the auditor's opinion, decisions were taken in the trust to fill posts that had been left vacant for budget purposes.

The Convener: Thank you for that clarification. Do you wish to respond, Mr White?

Mr White: I agree with that.

Mr Brett: I was aware of that report and that was the basis of my supposition. At the end of the day, we need to remember that Perth and Kinross Healthcare NHS Trust ended up with a £3.3 million recurring deficit. We have heard all the explanations for that, but we should keep it in mind because it has clearly contributed to the financial problems faced in Tayside.

Paul Martin: In earlier evidence, you highlighted cancer treatment and renal dialysis as services where development costs were not included in the 1999-2000 budgets. We have now heard from the managers of the previous trusts that funding for those developments were the subject of on-going discussions between the trusts and the health board. Does that mean that the budgeting problems that you described to us were not new, but simply badly managed by Tayside University Hospitals NHS Trust during 1999-2000?

Mr White: No. I do not accept that it was badly managed. We contained the pace of growth in cancer services, but short of withdrawing treatment from patients there was no way to switch off the costs that were already being incurred.

You heard from Mr Colville about the way in which patient treatment ramped up when the new cancer consultant was appointed. Treatments continued to build as the consultant built up her clinical work load during 1999-2000. Treatment was not stopped or withdrawn from patients, but we slowed the speed of that development. We also used evidence from other cancer centres to examine clinical effectiveness in terms of how certain drugs were being used, and whether there was sound evidence from a cost-benefit analysis to support their use. On the basis of that—and it was very much a clinical debate—some treatments were modified, which helped to damp down the increasing costs.

17:00

Mr Brett: I confirm that Tayside Health Board approved a cancer strategy in February 1998, which signalled investments totalling £4.5 million over the next five-year period. That included the development of the cancer centre at Ninewells hospital and the cancer unit in Perth. The issue was how quickly we could meet aspirations, particularly those of some of the new clinical staff who were coming to Ninewells. I expressed concern about that to Paul White in April 1999, because I was worried that things were running ahead of the funding that was available.

Paul Martin: Is it unusual not to include development costs in budgets in respect of cancer and renal dialysis treatment?

Mr Brett: It was unusual, but we did it. As I said, we invested more in cancer in that five-year period than in any other area.

Paul Martin: But you got the level wrong. Am I correct?

Mr Brett: The level was incorrect?

Paul Martin: Yes.

Mr Brett: I think that £4.5 million was a very significant investment. It was significantly more than was going into any other service development. I do not have figures for the level of investment in other parts of Scotland. Mr Colville indicated that perhaps Tayside was behind other parts of Scotland. I agree with Paul White that I took advice on the types of treatment and therapies that the new cancer specialists wanted to introduce. Over the past two years, we have brought the situation back under control.

The Convener: I am aware that this market day is wearing late, and we have further evidence to take. Scott Barrie will address the last part of this section, which is the senior management at the TUHT.

Scott Barrie: I will be brief, because we have touched on some of these points before. Mr Brett, given that the management of Tayside University Hospitals NHS Trust were all new to Tayside, what specific steps did you take to ensure that the handover between the old and new trusts was as smooth as possible?

Mr Brett: I would like to put on record that we entered the process jointly and collaboratively. Since the last hearing at this committee, our chairman Peter Bates has audited all correspondence regarding meetings and so on. I can advise that there were eight meetings between November 1998 and March 1999 at which either the new incoming trust chief executive or the finance director of the two new trusts were present. In addition, a further 21 items of correspondence relating to the future financial year were copied to the incoming finance teams. We were keen to involve them in the process, and I was keen that they should be aware of the issues.

Scott Barrie: There were eight meetings and 21 major pieces of correspondence, yet somehow or other, some of the major financial difficulties that the new trust was inheriting were not communicated.

Mr Brett: I repeat that at the April meeting of Tayside Health Board, when the financial strategy for the year was approved, it was made clear that both trusts had challenging efficiency savings targets, and that there were other cost pressures that the previous trusts had managed and which clearly the new trusts had to manage. They had been discussed at a joint meeting in March between the incoming trusts and us and there was a list of all developments for people to see. We were as open as we could be. We made clear what the position was. Although it was obviously going to be very challenging, I felt that the board had to set out the framework clearly so that both trusts knew what they were working within.

Scott Barrie: Mr White, you indicated earlier that during the six months leading up to the creation of the new trusts you were working approximately one day a week in Tayside, and perhaps up to two days a week towards the end of March. What opportunity did that allow you to find out about the situation that you were inheriting?

Mr White: I would like to put that in context. The committee's inquiry has rightly and understandably focused on the financial pressures that subsequently emerged, but in the lead-up to the formation of the new trusts there was a massive array of issues to come to terms with. For example, there were issues surrounding Stracathro hospital, of which some committee members are well aware, because in 1998 acute surgery had been withdrawn from Stracathro. There was a range of extant clinical issues, such as those relating to maternity and paediatric services in Perth, which remain to this day. There was the task of setting up the new organisations and management structures, and bringing together three very different trusts in Tayside.

The picture that I am trying to paint is one in which there was a range of issues. We could have been sitting here talking about the organisational structure or any other snapshot that one wanted to take. Finance was but one of the suite of issues that were being addressed. I repeat what I said earlier: yes, we knew that there were financial issues to be addressed, but their magnitude was not apparent.

Scott Barrie: In the 30 or so days in six months that you spent at Tayside, approximately how much time did you spend examining the financial situation that you were inheriting from the demitting trusts?

Mr White: I could not say. You are asking me to go back three years, so I could only guess. As I said, the financial situation was one of a number of issues. Do not forget that I was only one person in the organisation. The director of finance would have spent time on that issue as well.

Scott Barrie: Could you guess? I am asking about the order of priorities to try to understand what you have described to us.

Mr White: I may have spent a third of my time addressing finance, because it is one of the major accountabilities of the chief executive as the accountable officer for the trust. Finance and clinical governance would have been major issues.

Scott Barrie: At any time during that period, were you denied any information that you asked for or that you thought you should have been given?

Mr White: No, I cannot recall anything being denied.

Shona Robison: Given what you have just said about the difficulties of managing the process of change and all the issues that had to be resolved, is it possible that the financial situation was not scrutinised as it should have been, because of all the other difficulties that you faced? Did you take your eye off the ball with regard to the finances because you were focusing on all the other changes that had to be overseen?

Mr White: No. I think that I gave finance the appropriate attention. Bear in mind that I also had a director of finance who was coming into the new organisation, and his prime responsibility was to understand the financial regime that was being set up for the new trust. But again, within the process of understanding the regime, the sheer magnitude of the problem was not apparent. The task force report and the Auditor General's report brought out that evidence.

The Convener: Thank you for your evidence—

Mr White: For the record, could I make two brief points on some of the written evidence? First, I never at any time declined an invitation to attend Tayside Health Board to explain the position. That would have been quite contrary to what I was trying to do, which was to indicate that there was a shared problem. Secondly, every executive director of Dundee Teaching Hospitals NHS Trust who applied for a post in the new trust was appointed to a post, so in relation to Howard Waldner's evidence, I did not choose not to appoint any of the directors of Dundee Teaching Hospitals NHS Trust. There was an offer of appointment to Mr Waldner himself, which he accepted but subsequently declined.

The Convener: Mr Brett, do you wish to make a final comment?

Mr Brett: I just wish to reiterate that at the joint financial planning meeting that we had in March, we were aware that there were potential problems in the order of £12 million. Our forward strategy was based on making £5.2 million of savings and managing the other cost pressures.

The Convener: Thank you for your evidence. This has been a long session, so I suggest a five-minute break before we reconvene for the last section.

17:11

Meeting adjourned.

17:18

On resuming—

The Convener: I welcome Sir William Stewart and Mrs Frances Havenga to the meeting. These

meetings should not be endurance tests and it has been a long day, but these matters are important and the more evidence we gather for our report, the better. I thank the witnesses for their forbearance and great patience.

We will now consider whether incoming managers should have been aware of the need for funding for developments in cancer and renal services.

Mr Raffan: I probably do not need to recap, Sir William, because you have been present throughout the evidence-taking sessions. However, you obviously know about the cost of new developments, particularly in cancer treatment and renal dialysis, and whether there was funding to support those developments and services. As chairman of the TUHT, can you tell us the extent to which you were aware of and monitored those new developments, and ensured that there was sufficient funding to support them?

Sir William Stewart (Former Chairman, Tayside University Hospitals NHS Trust): First of all, I thank the committee for asking me to the meeting. It is late in the day, but I want to put on record the fact that Dundee Teaching Hospitals NHS Trust and the TUHT were—and are—good trusts, providing a good service for the people of Tayside.

As for developments in cancer treatment, my submission makes it clear that cancer services in Dundee were very poor for many years. The local population appreciated that fact, which is why there was voluntary fundraising. Three new consultant posts and three chairs were established, only one of which was funded by the health service.

When brilliant people are appointed—we were also seeking to upgrade the facilities—it is not for the management or the chairman to then say how patients should be treated. Those people were at the coalface of their profession and were providing a service that had not hitherto been available. As has been pointed out, there were increasing costs, particularly because new cancer drugs such as Taxol and Taxitere were coming on the market, and the clinicians were doing what they thought was best for the people of Tayside. Coupled with that was the fact that cancer was regarded as a clinical priority by the Government.

Furthermore, the Government said that anyone who turned up at hospitals had to be treated fairly and equitably. We were therefore faced with the dilemma that, on one hand, the Executive was telling us to ensure that we met our financial targets. It was asking questions such as “When are you going to close Stracathro hospital?” On the other hand, the Minister for Health and Community Care was telling us that the Executive did not want any political hassle. We were trying to sit in the middle and drive the TUHT through a difficult period. We were seeking funds from the health board for the extra cancer services we needed and finding out how we could redeploy funds within the trust. However, I support the clinicians’ view. If a patient needs and deserves treatment, it is not for me as the chairman of the board to say that they cannot have it.

Mr Raffan: So funding was a secondary issue and, as chairman, your primary concern was patient care and treatment.

Sir William Stewart: That must be my concern, because the NHS is for the people of Scotland. The issue is not totally about accountability. We are talking about individuals, not tins of baked beans on a supermarket shelf. Every patient who comes through the door has a problem and is worried and concerned. They deserve treatment, which must be given by the clinician, not the chairman.

Mr Raffan: You are clearly well aware that you were appointing clinicians who were at the cutting edge of cancer treatment. Furthermore, you were aware of the extra costs of the treatment they were likely to prescribe. As chairman, what action did you take to ensure that funding was available to support their work?

Sir William Stewart: First, we made representations to the NHS in Scotland—to people who knew the situation in Dundee. We were making comparisons with what had been happening in Aberdeen, which was our benchmark and which was better off than we were. Secondly, we sought additional funding from the health board. The health board had lots of other priorities—including the shifting of acute services into primary care. Thirdly, we were seeking, within our total funding, to move funds into clinical priority areas that the Government had identified—such as cancer services. Fourthly, and importantly, we had a tremendous response from the public of Tayside, encouraging us to develop the cancer centre, so that we could be as good as the rest of Scotland.

Perhaps I should describe the back-cloth against which we operated. There were different demands on us. The pace of technological change was increasing. I have mentioned that there were better, and more expensive, drugs. Better and more up-to-date staff were being appointed, and they wanted to prescribe the best drugs. There was a no-redundancy policy, which was a directive from the centre. Everyone who came through the doors of the trust and who needed treatment had to get treatment. Savings of 6 per cent per annum were demanded by the central coffers. We were told to stop using non-recurring funding to balance the books—yet that is what all trusts had been

doing in previous years; it had been an acceptable practice, but, all of a sudden, that changed.

There was an avalanche of new initiatives, such as the Scottish image guided microtherapy unit programme that Professor Cuschieri wanted to set in place. He got £1 million from the Scottish Executive for that. People may have asked: "Where is the recurring funding for that? The recurring funding costs may be £1 million to £3 million." I cannot remember what the right figure was, but we said, "We don't have £1 million to £3 million available." That initial £1 million is still in the Executive somewhere, because we did not have the recurring funding to carry the programme through.

In a difficult straitjacket, we were working as best we could to balance the books and give the best possible patient care. As chairman of the TUHT, I felt that my primary focus had to be on better care for the patient.

Mr Raffan: In retrospect, do you think that you, as chairman, paid sufficient attention to the funding issues of the developments in treatment? It has been suggested to us in evidence that you did not especially like to be overburdened with financial detail.

Sir William Stewart: I do not accept that. I was chief executive of a research council which had a budget higher than that of the TUHT. We balanced our books and got increased funding when I was chief executive.

I do not consider myself to be a finance officer. Why have a finance officer if I can do it? Why have a chief executive who is the accounting officer to the chief executive of the NHS in Scotland? My view is that you have to give people responsibilities. Those people should know their responsibilities and deliver on them. That will mean not only saving money, but redeploying your resources into national priorities.

The Convener: Although you have no financial responsibility as chairman of the trust, would it not have been prudent to have knowledge of the financial effects of trust decisions? May I ask why you appear to have gone the other way and to have deliberately prevented financial information reaching the trust board? We are told that you requested that the monthly report to the trust board by the finance officer be reduced to half a page of text with no numbers. How did that fulfil your obligations to the board, the public and the ministers?

Sir William Stewart: You have heard Mr Colville talk for quite a long time. At trust board meetings, he also talked for a long time, for much of which he was going down side streets. In my view, the important questions are these: is the fund in balance, is it in deficit, or is it in profit? Those are the key issues, and I wanted to know about them. I did not especially want to know about the trivia that any finance officer could sort out.

The Convener: So you did request half a page of text and no numbers?

Sir William Stewart: I cannot actually remember requesting half a page and no numbers. However, I was fully cognisant of the need to have at my fingertips knowledge of the broad thrust of the financial position of the trust at the time.

17:30

Shona Robison: I would like to ask a specific question about the trust's board meetings. Did Derek Maclean ever attend a board meeting and raise concerns about the state of the finances? Paul White seems to think that he did.

Sir William Stewart: Let me say first that Derek Maclean was an excellent medical director. The funding situation that was discussed came, I think, from the clinical managers. The clinical managers in the old trust reported to Derek Maclean, who alerted the board fully to what was going on. In the new trust, the clinical directors no longer reported to him; they reported to Paul White.

Shona Robison: Did Derek Maclean make the board fully aware of the cost pressures that he saw coming? Paul White said that they were not borne out in the paperwork. Are you saying that he attended a board meeting and told board members that he was concerned about cost pressures and a projected deficit?

Sir William Stewart: I cannot remember specifically whether he raised those issues at the board. However, it was certainly widely known among the senior management and the senior echelons of the trust that Derek had pointed out, on the advice of the clinical managers, that there were problems on the horizon.

Shona Robison: Was he taken seriously? Earlier, we heard that concerns were dismissed because they did not appear in the financial paperwork.

Sir William Stewart: Financial issues were taken seriously. The board's priority was to seek to balance the books at the end of the financial year. That is what it did, as it had done in the previous six or so years. In addition, one had to look towards possible future scenarios, which were taken into account as one sought to make overall financial savings.

Margaret Jamieson: In your written submission, Sir William, you indicate that developments in cancer treatment and renal treatment were not new, but came about as a reaction to the demands

of the public of Tayside. You say that the accountable officer was required to find, from within the total budget, a budget that could be set aside for that increased level of treatment.

Sir William Stewart: No—I was not saying that he had to find it all. I was saying that, within the total budget that he had, he had to seek—

Margaret Jamieson: Was that his budget or the trust board's budget?

Sir William Stewart: It was the trust board's budget. He had to seek to ensure that the total budget was targeted, where possible, towards priority areas. The Government had targeted cancer services as a priority, as I said before. There was a request to the health board, who helped us a little; there was a request from the voluntary sector; and everybody collectively tried to increase the funding that we had. I am making the point that the chief executive's role is to seek to use the total funding for which he has accounting responsibility as effectively as possible in support of priority needs—and cancer was a priority area.

Margaret Jamieson: Did the trust's board work up a business case for the expanded service? Did that meet with the health improvement programme that was identified by the health board?

Sir William Stewart: I have looked at the papers that were presented to me before I came here—I have not seen papers on this subject for a long time. The point that remains is whether there was information available on what the financial projections were and on what the priority areas were. I jotted this down from the section that is headed "Development of Financial Framework 1999/2000" of the paper that was considered on 11 February 1999. It says:

"The board has taken an inclusive approach to the development of its second Health Improvement Programme, and sought the inputs of planning partners and NHS Trusts (old and new)".

The same paragraph says that

"an explicit prioritisation mechanism, which is subject to wide consultation"

is being included.

That paper was signed by three chief executive officers—Tim Brett, Paul White and Tony Wells. That seems to me to be the appropriate way for those issues to be taken forward.

Margaret Jamieson: With due respect, that was not the question that I asked. I asked whether a business case was presented for the development of your cancer services and whether that met with the health board's health improvement programme.

Sir William Stewart: I cannot remember specifically, but my view is that the health board and the trust's board worked in conjunction to seek to deliver that. I cannot possibly remember whether that was by a specific business plan.

Margaret Jamieson: Surely, if you were going to employ an eminent cancer specialist, you would know exactly what the terms and conditions of hiring that individual were. You would know what hiring that individual would cost. You would know that there were associated support costs. Obviously, you would have had a budget. I would hope that that budget was examined by the trust's board and by the partners in the health board that was expected to make those funds available.

Sir William Stewart: If that is what you mean by a business plan, then of course one was put together.

The University of Dundee paid for one of the consultants.

Margaret Jamieson: We are talking about the consultant who was brought on stream and whose client base took four months to build up—the one that the health service was paying for.

Sir William Stewart: I cannot remember just now which one the health service paid for. The issue at stake—

Margaret Jamieson: Was that not Professor Rankin?

Sir William Stewart: The question is who was prescribing the expensive drugs. Professor Rankin spent more money on drugs than the other—

Margaret Jamieson: Was the fact that one individual was spending more than another not of concern to you?

Sir William Stewart: Do you suggest that we should have asked candidates during interview how much they would spend on patient care, and that if they said that they would spend a lot, we should not have appointed them?

Margaret Jamieson: I am saying that it is incumbent on you as chair of the board to ensure that public funds are spent appropriately and that everyone receives an equitable service. The chair should not just let things grow.

Sir William Stewart: With respect, whether public funds for clinical care are spent appropriately is not a matter for me as the chairman. It is a matter for the clinician who interviews patients and, on an analysis of their condition, decides what treatment they require and how much that costs.

Margaret Jamieson: With respect, we are sitting here—at 17:38—to try to get answers. If that is the kind of answer that we get, we know why we are in this situation.

Sir William Stewart: Are you suggesting that clinical services in Scotland should be dictated by limiting the cost of treatment to specific patients?

Margaret Jamieson: No. I am saying that, as chair of that trust, you had certain obligations to ensure that public funds were spent appropriately.

Sir William Stewart: I want to put on record that I believe that the use of public funds in support of better patient care is one of my top priorities.

The Convener: Do you mean on an unlimited basis?

No funding was provided for the 200 extra posts that were created in Tayside University Hospitals NHS Trust. Who authorised that decision?

Mr Raffan: On a point of order. You did not catch Sir William's eye, convener, although he wanted to respond to your previous question about funding being "on an unlimited basis". I would like to hear his answer.

The Convener: I beg your pardon, Sir William. I thought that you were not going to answer. Please do.

Sir William Stewart: I have forgotten what I was going to say.

The Convener: Who authorised the creation of the 200 extra posts in Dundee Teaching Hospitals NHS Trust, which were unfunded?

Sir William Stewart: I do not recall that the 200 posts were not funded. As I recall, funding was provided for 200 posts, but they were left unfunded. Later on, they were funded again.

The Convener: Am I right in thinking that the money was spent elsewhere—that the money that was allocated to the 200 posts was spent in other areas, and there was consequently no budget for those posts, because the same money could not be spent twice? Who authorised the filling of those 200 posts, despite the fact that the budget for them had been spent elsewhere?

Sir William Stewart: The filling of specific posts was decided by the chief executive officer in consultation with his executive group. In discussion with clinicians, that group decided what the priorities were in the HIP.

The Convener: So, the chief executive officer authorised those 200 extra posts.

Sir William Stewart: That is true.

The Convener: Thank you. We will now consider the extent to which the accountability framework provided robust controls for the activities of the health bodies.

Paul Martin: Sir William, you will be aware that the senior staff who were recruited to manage Tayside University Hospitals NHS Trust had no experience of the health service in Tayside. Was it a predetermined policy of the trust's board not to recruit anyone from Tayside University Hospitals NHS Trust?

Sir William Stewart: Do you mean from Dundee Teaching Hospitals NHS Trust?

Paul Martin: The point is that none of the senior staff who were recruited to manage Tayside University Hospitals NHS Trust had experience of the health service in Tayside. Was that a predetermined policy of the trust's board during that intervening period?

Sir William Stewart: No, it was not a predetermined policy of the board. We had an excellent executive team in Dundee Teaching Hospitals NHS Trust. Nevertheless, the short leet of CEOs that we were given, who were not chosen by us, but by the Scottish executive centrally, did not include anybody from Tayside.

Paul Martin: So, you are certain that, during the recruitment process, there was no policy—

Sir William Stewart: There was no bias against people from Dundee Teaching Hospitals NHS Trust.

Paul Martin: In the interviewing process, there was no suggestion that somebody who was previously employed in Tayside was not the kind of individual that you were looking to—

Sir William Stewart: Let me reiterate: we had an excellent executive team.

Paul Martin: What steps were taken to ensure that the transition from the former management to the new management was handled effectively? None of the new senior management had previous experience in Tayside. What steps were taken to ensure a smooth transition?

17:45

Sir William Stewart: There was continuity, as certain members of the new board had been members of the former board. I was one of those people. In addition, the clinical director on the executive team of Tayside University Hospitals NHS Trust had been the clinical director of Dundee Teaching Hospitals NHS Trust, and the nursing director of Tayside University Hospitals NHS Trust had been the nursing director of Dundee Teaching Hospitals NHS Trust. At meetings with the health board and others, we sought to ensure continuity as best we could.

Paul Martin: So, steps were taken to ensure continuity.

Sir William Stewart: In my view, yes.

Mr Quinan: You said that you were presented

with a short leet by the Scottish executive. Who prepared that short leet?

Sir William Stewart: The Scottish executive prepared it.

Mr Quinan: Are you aware of whom exactly prepared the short leet? Is that information available to the committee?

Sir William Stewart: You should ask the Scottish executive who prepared it. The chief executive officer of the NHS in Scotland took the lead in it, and the director of human resources—Gerry Marr—was instrumental.

Mr Quinan: In addition to that short leet, were you given any indication by the Scottish executive of its preferred candidates?

Sir William Stewart: No. The candidates were presented to us and we were given freedom to choose between them.

Scott Barrie: On a point of order. It is late, and perhaps I am getting confused, but we keep talking about the Scottish executive. We surely mean the executive of the NHS in Scotland rather than the Scottish Executive.

Mr Quinan: Yes.

Scott Barrie: But we keep talking about the "Scottish executive".

Sir William Stewart: Do not worry: we are not blaming members.

Mr Quinan: Yet.

Sir William Stewart: Frances Havenga reminds me that I should be talking about the management executive.

Mr Quinan: Thank you, Sir William.

Mrs Havenga, what was the role of the health board in the appointment of senior managers to the new trusts? Were you in a similar situation, being presented with a short leet from which you recommended candidates?

Mrs Frances Havenga (Former Chairman, Tayside Health Board): Do you mean candidates whom we recommended to the trusts?

Mr Quinan: Yes.

Mrs Havenga: No. The health board was not involved in those appointments.

Mr Quinan: Had you no involvement whatever?

Mrs Havenga: No.

Mr Quinan: Did the health board seek any assurances from Tayside University Hospitals NHS Trust that steps were being taken to ensure a smooth handover, given the fact that all the senior managers were new to the structures?

Mrs Havenga: As Sir William Stewart said, meetings took place regularly between the members of the former trust board and the members of the new board, prior to the handover. Mr Brett set up a number of meetings with a view to ensuring a smooth handover.

Mr Quinan: At those meetings, were concerns expressed by the health board about the introduction of an entirely new management structure?

Mrs Havenga: I am not in a position to answer that—I was not at those meetings. The board was not involved in the meetings, which were executive meetings.

Mr Quinan: They were purely executive meetings. Of those who attended those meetings, who could answer my previous question?

Mrs Havenga: Members of the executive teams could answer it.

Margaret Jamieson: Can you explain your role as chair of Tayside Health Board and your relationship with ministers and the Scottish health department?

Mrs Havenga: I have outlined that role in my written submission. I do not think that the committee would want me to read it out.

My relationship with the ministers was conducted normally through the chief executive of the NHS, but I think that we had more direct access to the previous minister who was responsible for health than to the current minister. Direct access was much easier then.

Margaret Jamieson: What was your relationship with the health department?

Mrs Havenga: Will you expand on that?

Margaret Jamieson: What was your relationship with Mr Scaife, the chief executive of the NHS in Scotland at that time?

Mrs Havenga: I had a reasonable relationship with Mr Scaife.

Margaret Jamieson: Do you think therefore that any of the relationships in any way inhibited the management of health services in Tayside?

Mrs Havenga: No.

Margaret Jamieson: Do you think that you were provided with a clear framework of accountability?

Mrs Havenga: Do you mean financial accountability?

Margaret Jamieson: I mean accountability in terms of, for example, budgeting, providing the forward work plan and the strategy for improving the health of the people of Tayside?

Mrs Havenga: No. As members have heard, financial accountability was through the accounting officers. There was no other problem.

Margaret Jamieson: I refer you to the accountability reviews that were conducted by Geoff Scaife. Obviously, the letters were addressed to you. One is dated 18 August 1998, and the other is dated 8 July 1999. Are you saying that those do not refer to financial situations that related to Tayside Health Board?

Mrs Havenga: No, I am not saying that. They do. They cover everything.

Margaret Jamieson: How can you therefore assert that you were not responsible for the financial well-being of the health board?

Mrs Havenga: As I have said, I was not the direct accounting officer.

Margaret Jamieson: That is extremely difficult to understand, given that the chief executive of the NHS in Scotland wrote to you detailing the outcome of the accountability reviews of both years to which I have referred, and provided a copy to Sir William Stewart and Murray Petrie.

Mrs Havenga: Yes, but Geoff Scaife also refers to the teams.

Margaret Jamieson: He also indicates the need for your board

"to become clearer about its strategic goals so that individual initiatives were part of a cohesive and affordable package".

Do you think that the chief executive held you—as chairperson of Tayside Health Board—to account and gave you direction for the board?

Mrs Havenga: Yes, I suppose that he gave direction to the board through me.

Margaret Jamieson: Do you therefore accept that there is an accountability process through you as the chair of Tayside Health Board directly to the chief executive of the NHS in Scotland?

Mrs Havenga: That was the process.

Margaret Jamieson: Did you buy into that process?

Mrs Havenga: Yes.

Margaret Jamieson: Were you happy with it?

Mrs Havenga: The process existed. It was not up to me to be happy or otherwise.

Margaret Jamieson: I get the feeling that you might have been dragged kicking and screaming into the process.

Mrs Havenga: Not quite.

Margaret Jamieson: Not quite, but not far from it.

Mrs Havenga: The experience was not always pleasant, but we had to go through it every year. Many of us did not, perhaps, enjoy the experience, but we accepted that many of the matters that it covered should be covered.

Margaret Jamieson: After receiving the letters from the then chief executive, Geoff Scaife, how did you progress the work that he identified as needing to be done to comply with the initiatives that were set by the NHS in Scotland? What programme of work did you ask your board to take forward in conjunction with the trusts?

Mrs Havenga: Those letters were after my appointment. Prior to that, they did not see the light of day after they came to Dundee. After my appointment, the letters were made available to the board and to the members of the trust.

Margaret Jamieson: Was that something that you did?

Mrs Havenga: Yes. I felt that it was important that all the members of the board and of the trust board, and the officials of the trust, were made aware of what was required, so that we could work together as a team to achieve the objectives.

Margaret Jamieson: Did the basis of the accountability reviews have an impact on how you shaped your health improvement plan for the following year?

Mrs Havenga: It had to be taken into account.

Margaret Jamieson: Did it also influence the way in which the budget for the following year was worked out?

Mrs Havenga: Yes. Again, all the comments that were made in the chief executive's letter had to be taken into account.

Margaret Jamieson: How were they benchmarked to ensure that they had actually been delivered?

Mrs Havenga: I am not in a position to answer that question.

Margaret Jamieson: Do you think that, at any time during the accountability reviews, the chief executive got it wrong or caused you concern?

Mrs Havenga: I really cannot recall any specific cases of that.

Mr Quinan: I have a question for both Sir William Stewart and Mrs Havenga. Sir William stated that he believes that financial accountability rested with the chief executives, and that that presented problems to the health board, as the important issues were dependent on finance, but the chief executives' line of accountability was to the department rather than to the board. Mrs Havenga also stated that there were problems

with the line of accountability from trusts to health boards. She quoted an example of a chief executive who refused to attend a meeting called to discuss his trust's financial deficits. I ask both Sir William and Mrs Havenga to give me an idea of what they believe were the failures in that structure. Perhaps, Mrs Havenga, you would also be kind enough to tell us which chief executive you were referring to and on what date that meeting took place.

Sir William Stewart: The difficulties, as I saw it, lay in the two-pronged requirements of what we had to satisfy. We had to satisfy what the minister wanted generally and what the chief executive officer of the management executive wanted, which was financial accountability and probity.

Mr Quinan: Are you suggesting that there was effectively a clash of priorities, as the drive to meet financial targets and the need to deliver the minister's health policy would not match?

Sir William Stewart: As I said, constraints were being put on us by the fact that there were no closures or redundancies, everyone had to be treated, the budget was limited, blah blah blah. It was like being asked to drive from Dundee to London in two hours without exceeding the speed limit and with only enough fuel to get to the border.

Mrs Havenga: The health board allocated the funds to the trusts and provided a health improvement programme, but the trust was then accountable for the finances not back through the health board, but directly to the management executive. That caused a problem, because the board had no means of forcing the trust to toe the line.

As for the meeting that you asked me about, I was referring not to a specific meeting but to a request that was made at one of the health board's board meetings—by, I believe, the chairman of the audit committee and one other member—that the chief executive of Tayside University Hospitals NHS Trust should attend a meeting to give us chapter and verse on the growing problem. The message that we got back was that the finances of the trust were not health board business.

Mr Quinan: Was there a statement of a date in the request for the chief executive to come to the board?

Mrs Havenga: No, there was no statement of a date. It was a general request.

Mr Quinan: Was that chief executive Paul White?

Mrs Havenga: Yes.

Mr Quinan: So Mr White would be correct in saying that he was never officially invited.

Mrs Havenga: That is correct. There was no written invitation. The invitation was made at an open board meeting.

Mr Quinan: Thank you.

18:00

The Convener: To finish off, may I ask you a question, Sir William? Did your relationship with ministers and the department inhibit management of the trust? Were you provided with a clear framework of accountability?

Sir William Stewart: There were no problems.

The Convener: Thank you for being succinct. In the event that you were restricted from dealing with an issue in the way that you considered most appropriate, what action did you take?

Sir William Stewart: There were no particular issues to which I could not respond.

The Convener: Thank you. We have reached the end of a long day, so if you wish to make a final statement, now is the time to do so.

Sir William Stewart: Thank you for inviting us. The health service in Scotland is hugely important. We in Tayside are committed to a health service that is as good as possible within the parameters in which we have to operate. The Prime Minister admitted to David Frost that expenditure on the national health service was too low. That was an honest and brave statement to make. It is too low.

"Cancer Scenarios", which was published this week by the NHS in Scotland, says that the cancer position in Scotland is grim. "Healthcare UK 2001", which was published last week by the King's Fund, says that the Government is in a muddle over targets for health care spending.

Mrs Havenga: I have nothing to say, other than to reiterate Sir William's comments regarding the health service in Tayside. We have a dedicated, experienced team of medical professionals. We are lucky to be served by people of that calibre.

The Convener: Thank you. Mr Peter Bates would like an opportunity to speak.

Mr Bates: Having been given the privilege of being here this afternoon, and finding myself back again with Mr Scaife and Mr Jones, I would like to make a few comments. I respect the fact that the preoccupation of members of the Audit Committee is to establish what has occurred and how such a situation arose. That is important, because there are always lessons to be learned. There is never room for complacency in any public service.

We need a culture in which chief executives, who are paid significant sums of money, understand the importance of being held accountable—of coming into rooms such as this

and being frank and open. The Parliament can encourage such a culture. I assure members of the Audit Committee that, as long as the minister allows me to remain as the chair of NHS Tayside, chief executives who work within Tayside will be expected to perform to a much higher standard of competence than they have in the past.

Putting that on the record might seem strong action, but it is an important statement. We are talking about the health service of the people of Tayside, who, like you, need to have absolute confidence in senior managers. We need a culture of rigorous accountability. That is why I believe that the minister and the Executive made a wise and important decision to introduce unified boards to make it much clearer where accountability lies and much more difficult for people to say, "This is not to do with me."

My second point is that, as Sir William Stewart said, the chief executive is the statutory accountable officer. It is important that that is not fudged and that it is not fudged in the restructuring of the health service. Public service officers who want to occupy those roles—we need to remember that they are some of the most highly paid public service officer roles in Scotland—must understand the culture of accountability.

I was tempted to draw the convener's attention to the fact that I wanted to make a contribution when Margaret Jamieson was asking important questions of the first set of witnesses about who was responsible for what. What Margaret Jamieson was really getting at relates to management. Management is not about saying, "This is not to do with me," whether or not one is in the public services. Of course it is difficult, and Sir William Stewart is right to say that there is a complex line between clinical accountability and management accountability. Just because someone works in the health service as a senior public chief executive does not mean that they can stand back and allow expenditure to develop beyond the means that they have at their disposal. Management is about getting the balance right; it is about management.

I would be failing in my duty if I did not put it on record—I gave members this assurance when I appeared before the committee before and I have given the citizens of Tayside the same assurance—that I will be absolutely honest and transparent in everything that I do and say in discharging my role.

Following my attendance at the previous meeting of the Audit Committee, I decided—as was said by one of the chief executives earlier—that it was right that I did a comprehensive audit trail examination. I wanted to find out what had gone on. One of the matters that the committee has pursued vigorously today is what happened when the storm clouds were gathering financially. When were they seen on the horizon? That is a matter of judgment. I can give the committee only my judgment, which I hope is measured and informed. I think that it would be proper for me to say that the storm clouds were clearly visible in September and October 1998. The overwhelming balance of evidence that has been presented to the committee today has supported that judgment. It is then a matter of judgment as to how large the storm clouds were, but I do not think that that is really the issue. The issue is whether there were storm clouds and how they were grasped.

My final point, convener—and I am grateful to you, as always, for your indulgence in allowing witnesses such as me to make contributions—is the great sense of desperation and frustration that I feel about the need to move on. I appealed to you all as MSPs at the previous meeting and I appeal to you as the Audit Committee today—I know that the committee is going to have another meeting on this matter. As the new chair, I desperately need the support of MSPs, the Audit Committee and many other people to move us on in Tayside. We must draw a line in the sand. We must learn the lessons, but staff are finding it demoralising to be constantly dragged backwards. I hope that, when the committee concludes its inquiry, it will find ways of supporting the new NHS Tayside board to carry matters forward constructively and positively. I am grateful for the opportunity to make a contribution.

The Convener: The committee is well apprised of the need to move on and of the need to be detailed in our investigation and in our findings.

Peter Bates has raised wider issues; we will no doubt return to those in a future evidence session. He mentioned accountability through our democratically elected Parliament—that relates to this committee's duty.

I ask committee members to stay for the continuation of the meeting in private. I thank all our witnesses and the general public, as well as Parliament staff and officials. This has been the longest-ever single meeting, but it has been on an important matter.

18:09

Meeting continued in private until 18:22.

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