AUDIT COMMITTEE

Tuesday 12 June 2001
(*Afternoon*)

Session 1

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AUDIT COMMITTEE
9th 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

Mr Peter Bates (NHS Tayside)
Mr Trevor Jones (Scottish Executive Health Department/Chief Executive of the National Health Service in Scotland)
Mr Geoff Scaife (Former Chief Executive of the NHS in Scotland)

CLERK TO THE COMMITTEE

Callum Thomson

SENIOR ASSISTANT CLERK

Anne Peat

ASSISTANT CLERK

Seán Wixted

LOCATION

The Chamber

Scottish Parliament

Audit Committee

Tuesday 12 June 2001

(*Afternoon*)

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

The Convener (Mr Andrew Welsh): I have apologies from Nick Johnston. There appear to be no others.

Items in Private

The Convener: Agenda item 1 concerns today's committee business. I seek members' approval to take items 2 and 6 in private. They involve the committee's preparation for and review of today's evidence. Does the committee approve our taking that business in private?

Members *indicated agreement.*

The Convener: We therefore go into private session for item 2.

14:03

Meeting continued in private.

14:12

Meeting continued in public.

Consultative Steering Group Principles

The Convener: In regard to agenda item 2, the Procedures Committee is undertaking an inquiry into the extent to which the consultative steering group principles are being implemented in the Parliament. Committees are invited to make submissions on the matter, should they consider it appropriate. There is no obligation on individual committees to do so, and all MSPs and their staff will be asked for their views individually. I remind the committee that any written submissions should be made by 26 June.

I am asking whether the committee wants to make such a submission. If so, it would be sensible for us to nominate one member to undertake that. Members should remember the time pressures that the committee and the clerk will be under between now and the recess. Do members have any comments on that suggestion?

Mr Keith Raffan (Mid Scotland and Fife) (LD): Our next meeting is on 26 June. If we decide to make a submission, we will have to schedule an extra meeting to go through it.

The Convener: That would be quite difficult to arrange, as our next meeting has been scheduled.

Mr Raffan: We could e-mail the submission to each other. If I might repeat what I said in private, it might be helpful if I read the CSG report again, as I have not read it for a while. It would also be helpful if the clerks gave us details on which aspects impact on the Audit Committee. I do not want to steal Mr Quinan's thunder.

Mr Lloyd Quinan (West of Scotland) (SNP): I do not want to repeat myself, as Keith Raffan has successfully managed to do that.

The Convener: I suggest that the clerk e-mails to members any specific references to the Audit Committee. That would be helpful.

Mr Raffan: We can make our own submissions, in view of the short time scale.

The Convener: Okay, thank you.

Equal Opportunities

14:15

The Convener: Agenda item 4 is on mainstreaming equal opportunities in committees. The Equal Opportunities Committee is seeking support from all committees for this project. We seek a nomination for someone to attend a two to three-hour workshop on the evening of 20 June. If a member of the Audit Committee is keen to get involved and have his or her name put forward, they should let us know.

I suggest that this may be more appropriate for the subject committees than a committee with a very specific remit such as the Audit Committee. However, it is an important initiative and I ask any member interested to make that known to the clerk, for transmission to the Equal Opportunities Committee. Is that agreed?

Members *indicated agreement*.

National Health Service (Tayside)

The Convener: Agenda item 5 is on NHS bodies in Tayside. Before I welcome the witnesses, I welcome our colleagues John McAllion and Shona Robison, who have a strong interest in Tayside and in this subject. They are both welcome.

This is the final evidence session on the report by the Auditor General on the NHS in Tayside. I welcome the witnesses who are giving evidence today and their assistants. Mr Geoff Scaife is the former chief executive of the NHS in Scotland, Mr Trevor Jones is the current chief executive and Mr Peter Bates is the current chairman of Tayside Health Board.

The questions in today's meeting fall into three main areas. First, whether the Scottish Executive health department should have been aware of potential financial difficulties in Tayside health bodies. Secondly, whether the system of accountability governing the NHS in Scotland has been sufficiently clear and robust and, thirdly, whether the improvements in governance indicated by the reforms set out in the health plan will prevent a repeat of the problems experienced in Tayside and when those improvements will be in place.

We will begin the evidence session by putting general questions to Mr Scaife. Could you clarify your role in the financial matters of the NHS trusts, Mr Scaife?

Mr Geoff Scaife (Former Chief Executive of the NHS in Scotland): Throughout the period until July 2000, I was chief executive of the NHS in Scotland. As such I was the senior adviser to the minister on matters to do with the NHS in Scotland, as a civil servant here in Edinburgh. I was also the accountable officer in terms of value for money and governance for the budget for the NHS in Scotland. Obviously, I was not responsible for operational management of the service locally.

The Convener: What powers or duty did you have to intervene in the case of serious financial difficulties or failures at local level?

Mr Scaife: Essentially, the powers were to ensure that local health bodies, whether NHS trusts or health boards, had coherent and robust financial and service plans. We would insist on proper planning and that the plans met the policy objectives of ministers—that was what the money was to be used for. We had systems in place to ensure that there was monthly monitoring of financial performance and regular monitoring of activity and the delivery of care locally.

We were sitting at a national level and

monitoring the performance of local health bodies: local statutory bodies that were responsible, in their own right, for planning services, in the case of health boards, and for delivering services within budgets, in the case of NHS trusts.

The Convener: You monitored what was done, so that you would know what was happening. When did you first know about the financial difficulties and deficits experienced by Tayside health bodies in 1999-2000, and what did you do about them?

Mr Scaife: We were aware of financial problems in the former Perth and Kinross Healthcare NHS Trust towards the end of 1998 and were active with local management in ensuring that a robust recovery plan was put in place. We were involved with both the trust and the local health board in ensuring that arrangements to provide temporary non-recurring financial support through the investment of capital receipts were made against the back-cloth of a sensible, deliverable, recurring recovery programme.

As for the new teaching hospital trust and the region generally, it was not until 25 August 1999, when the July monitoring returns came in, that we became aware that there was a significant financial problem in the major acute teaching hospital trust in Tayside.

The Convener: If you were told in February that all was well, but told in July that all was not well, does not that show a failure in the monitoring process?

Mr Scaife: No, it does not show a failure in the monitoring process. That was telling us what the local management believed was happening on the ground. Detailed figures came in each month and, as I explained, we did not know until 25 August 1999 that there was a significant financial problem in the acute hospital trust.

The Convener: As the chief executive of the NHS in Scotland, you were the eyes and ears of the minister and the official directly responsible to Parliament for the good, overall financial performance of the NHS. It is clear from the evidence that we have heard that the trust had previous financial problems, such as a pension and perks scandal. There was an over-provision of services and capital was used to fund revenue projects. Was it not your duty to intervene? If you were not the accountable officer, who at central Government level had the responsibility to find out what was going on?

Mr Scaife: You have raised several issues, convener. As for pensions and perks, that is going back further into history. It concerned the way in which staff in the health board were remunerated and their expenses for removal and subsistence.

The Convener: Such a climate should have alerted central Government to the fact that problems were inherent in the system and that they would be transferred to the new system. Surely the monitoring procedures should have picked that up earlier.

Mr Scaife: We are comparing apples with pears. The pensions and perks issue was addressed fully at the time.

The Convener: Indeed, but at that time there were clearly problems. In September 1998, Perth and Kinross Healthcare NHS Trust also produced deficits. You were told in February that all was well. When matters were transferred, surely your monitoring system should have picked up what was happening then, but which was revealed two months later.

Mr Scaife: We are talking about a period when the NHS in Scotland was being reorganised from 47 to 28 NHS trusts, which happened between December 1997—when "Designed to Care" was published—and March 1999. During that period, as is always the case when restructuring is taking place, attention was paid to financial performance, new teams arriving, what the new financial regime would look like and how the new trust would be managed. Throughout Scotland, issues arose in connection with how tight the budget would be for the new trusts entering the new financial year 1999-2000.

Tayside was not alone in that respect; other health systems across the country had significant issues to address. We were in touch with all of them; we were ensuring that those issues were addressed; and we were working with local management to ensure that robust plans were in place. In Tayside, it took significantly longer to get there, but that was not a problem of financial monitoring, nor of the extent to which we were in touch with health boards and trusts throughout the country.

The Convener: The details of this question will be followed up by other committee members, but can you tell us how often you personally met members of the boards and senior managers of the Tayside health bodies to discuss their financial problems?

Mr Scaife: I was in regular contact with health boards and NHS trusts throughout the country. I have already explained that, in the period leading up to the creation of the new NHS trusts, there were financial hotspots around the country. I and my senior staff were very active around the country, problem solving.

In relation to Tayside, the record will show that there was a formal accountability review with the chairman and other members of the health board and of the NHS trusts in May 1999, as well as

exchanges of letters. Throughout the period, routine monitoring was showing that the NHS trusts expected to achieve financial balance. Once we became alerted to the financial problem, on 25 August 1999, there were then regular meetings. My first meeting after that date, with the chief executive of the health board and with the two NHS trusts, was on 15 September, although my staff would also have been in contact in the interim. There were then regular meetings.

The next big meeting, on 15 October 1999, was face to face with the Minister for Health and Community Care and Tayside Health Board. Thereafter, there were further regular meetings. It was not a case of our being hands-off or far from the action. We were involved and were trying to support the health board and the local trusts to resolve their financial problem.

The Convener: You are dealing with £5 billion of public expenditure, scattered throughout Scotland—how much use is a monitoring system that could not pick up in February a massive problem that emerged two months later? Is that adequate monitoring? Who was in charge of it? At a central level, you have an overview of the whole of Scotland; you are the accountable officer for financial matters, yet, in the space of two months, what appeared to be a perfectly correct situation turned out to be a large deficit. I repeat: is that adequate monitoring?

Mr Scaife: The monthly monitoring system is very robust. The first indication that we got that there was a financial problem that would carry forward into the next year was in August 1999. I have explained that there were financial issues relating to Perth and Kinross, and I have explained how those issues were addressed. Part of the services in Perth and Kinross were transferred into the new teaching hospital trust, which was created from 1 April 1999. There was of course a crossover, in terms of the consequences of resolving that financial problem. We were not aware that there was a financial problem that would cause the Tayside trusts to miss their financial targets until the July monthly report came in on 25 August.

The Convener: We will now look in more detail at whether the health department was fully aware of potential financial difficulties in the Tayside health bodies. I ask Scott Barrie to lead in this section of questions.

Scott Barrie (Dunfermline West) (Lab): Good afternoon, Mr Scaife. You have stated that you did not think that the reorganisation of the health service in Scotland was a particular problem that resulted in financial difficulties in Tayside and that you did not think that the financial reporting systems were a particular problem either. In your letter of 2 May, you say that you considered the reorganisation of the NHS in Tayside to be no more difficult than in other areas of Scotland, and that the move from four trusts to two trusts should have resulted in financial savings.

Other witnesses have told us that they became aware of the emerging deficits only in 1999-2000, when the process of disaggregating information, which was, I think, unique to Tayside, was taken forward. Should the health department have been more alert to the particular problems in Tayside? What action was taken to ensure that the new health bodies had all the necessary arrangements in place from day one?

Mr Scaife: There are two issues. I believe that the Auditor General mentioned the uniqueness of the reorganisation in Tayside. In parts of Tayside, the hospital trust and community services were unified. They had to be separated into the new primary care trust and the new Tayside University Hospitals NHS Trust. That was not the case in other parts of Scotland. We were aware of that problem and were involved in ensuring that the issues were disentangled properly.

We were also aware, as I said in earlier evidence, that there was a financial problem in Perth and Kinross Healthcare NHS Trust. We were aware of that problem and were addressing it with a package of proposals that involved the expenditure of non-recurring moneys as a bridge until recurring savings could be made to balance the books on a recurring basis. We were aware of the complexities that were involved in separating the trust and of the financial problems that were inherent in the trust.

14:30

Scott Barrie: You say that you were aware of the problems, but there were two unique factors: the financial difficulties of the Perth and Kinross Healthcare NHS Trust, which had been identified, and the fact that Tayside was the only area in the country in which the primary care and acute services of two trusts were coming together into one organisation. Given those two unique factors, what steps did the health department take? As the situation was not replicated in other parts of Scotland, Tayside should have received further assistance, or a new way of dealing with the situation should have been devised. At least, there should have been a way of ensuring that the financial information, which was crucial in that part of Scotland, was in place from day one.

We have heard from the people who took over the new trust that they were unaware of the previous financial difficulties and that it was only during the financial year that the severe problems came to light. However, you have told us that the health department was aware of the extra

difficulties that existed.

Mr Scaife: I said that the health department was aware of the unique situation in Perth and Kinross Healthcare NHS Trust, with community services and hospital services having to be separated. Community services were being transferred to the primary care trust, which was to be established from 1 April, and hospital services were to be transferred to the new university teaching hospital. We were aware of that and were working hard with all the trusts in Scotland to ensure that the accounts of the old trusts were closed properly and that new budgets were set for the new trusts. Tayside was not the only place in Scotland that had to deal with complex mergers of NHS trusts.

I have emphasised the uniqueness of the fact that community services were being separated from hospital services. However, all the primary care trusts that were created from 1 April 1999 took over significant responsibilities from the 15 health boards, such as the responsibilities for the four contracting professions—family doctors, dentists, optometrists and high street pharmacists. That involved a complex series of restructuring exercises. The situation in Perth and Kinross was different, but there was considerable complexity elsewhere. My staff were active throughout the country. We were doing everything we could to support local people and to ensure that the transition was as smooth as it could be.

I have made the point that there was a financial problem in Perth and Kinross that concerned about £3 million. The problem was known about and was being addressed. Arrangements were being put in hand. Agreements were struck to allow non-recurring moneys to be used and the stage was set for the problem to be dealt with on a recurring basis.

Scott Barrie: You say that the health department was aware of the situation in Tayside, and you have repeated to us what your letter said—that, although other parts of Scotland faced equally complex issues, there were specific issues relating to Perth and Kinross. Can you give us some indication of what practical help you gave to the bodies in Tayside at the time of disaggregation?

Mr Scaife: We gave practical guidance on the accounting systems and the closure of the 47 NHS trusts that were disappearing—they were being disestablished and 28 new NHS trusts were being created from 1 April. We had to be confident that the people from the former trusts would still be in place to close down the books and be accountable for the performance of their disappearing trusts. We had finance staff and others working in the field to ensure that everything was done to make the transition as smooth as possible.

Scott Barrie: I appreciate the fact that that was what you were doing for all the new health authorities, but—given that you have stated that there were specific issues relating to Tayside—I am asking what extra assistance you gave to the bodies in Tayside. Evidence that we have taken indicates that the people who came into the new bodies were unaware of many of the difficulties that you suggest the health department might have had some inkling about.

Mr Scaife: What I have said is that the health department was aware of a financial problem in Perth and Kinross Healthcare NHS Trust, which was of the order of £3 million. That fact was not only well known, but was being actively addressed. Agreements were struck with the health board, the local trust and the health department on the investment of non-recurring moneys to tide over the bodies until recurring solutions could be established. That process was actively managed and my former director of finance was involved with it personally to ensure that it was dealt with properly. That is one set of issues.

There is another set of issues. Uniquely, community services were transferring from Perth and Kinross Healthcare NHS Trust to a primary care trust. Community services throughout the rest of Scotland were also transferring to primary care trusts. The services from the four contracting professions were transferring from the 15 health boards to the primary care trusts. I am trying to give you a sense of the complexity of moving from 47 NHS trusts and 15 health boards to 28 NHS trusts.

The Convener: I ask for some clarity. Are you saying that Perth and Kinross was the only Tayside health authority that was using non-recurring moneys and the only health authority in Tayside with financial problems?

Mr Scaife: No, I am not saying that. I am responding to the point about the uniqueness of the transfer of community services from Perth and Kinross Healthcare NHS Trust to the new primary care trust. That was the issue.

The Convener: So, central Government was aware of problems elsewhere in Tayside at that time.

Mr Scaife: Central Government was aware of the fact that, throughout the country—

The Convener: Specifically in Tayside?

Mr Scaife: Let me answer the question. Central Government was aware of the fact that, throughout the country and in Tayside, there were considerable financial pressures in the system as the new financial year began. This is about people positioning themselves for the new financial year.

What we were not aware of was the fact that local managers in the trust and in the health board believed that the pressures that they faced were such that they would not be able to fulfil their financial duties.

Of course we were aware that there were significant financial pressures in the system throughout the country—they arise in every budget round, every autumn. If you went to any health board in Scotland this autumn and asked whether it was experiencing significant financial pressures that it would carry forward into the next year, you would get a long list of financial pressures.

There is a difference between people talking about financial pressures and people stating in their authoritative returns to central Government that they believe that they have a financial problem that will cause them not to fulfil their financial duties. There is an important distinction between people saying that they face financial pressures and people saying that there is a real problem that puts them at risk of not achieving their targets.

Mr John McAllion (Dundee East) (Lab): You said that the department did not become aware of significant financial problems in Tayside until 25 August 1999. The Auditor General's report says that Tayside University Hospitals NHS Trust

"first expressed concerns about its financial position in April 1999 when it sought from the Department an additional non-recurring £3 million allocation to cover the gap between its income and the cost of services it was expected to provide".

The trust's approach was rebutted by the department. Are you saying that the £3 million was not a significant sum?

Mr Scaife: No, I am not saying that. I am drawing a distinction between the financial problem of about £3 million that we knew about in Perth and Kinross Healthcare NHS Trust—

Mr McAllion: Did the £3 million that is referred to in the Auditor General's report relate specifically to the situation in Perth and Kinross?

Mr Scaife: I believe that it did. I received a letter from the chairman of Tayside University Hospitals NHS Trust in April 1999 that advised me of a visit that Sam Galbraith had made to Tayside Health Board at that time. It said that the minister had said that none of the new trusts that were being launched in April 1999 would have a financial problem

"because of the actions of the predecessor Trust".

In the letter, the chairman of the trust, Sir William Stewart, said that he had a problem because he had inherited some services from Perth and Kinross Healthcare NHS Trust—Perth royal infirmary—and that a deficit of £3 million had

"been inherited from the former Perth and Kinross Trust by Tayside University Hospitals Trust".

He said:

"I have to say that it will be impossible to close a gap of that magnitude within the Trust's first year of operation"

and asked that

"a non recurring allocation of finance of around £3 million be allocated to this Trust for the financial year 1999/2000".

Mr McAllion: What changed between February, when Bill Stewart was involved in drawing up the financial framework that would ensure that the new trust could break even and would have a balanced budget in the following year, and less than two months later, when he said that the trust could not break even and that an extra £3 million would be needed? Did that set the alarm bells ringing?

Mr Scaife: No, because we were aware of the financial problem in Perth and Kinross Healthcare NHS Trust.

Mr McAllion: Were you confident that the £3 million about which Tayside University Hospitals NHS Trust was complaining in April 1999 could be overcome easily in the course of the year through savings, for example?

Mr Scaife: No. I did not say that it would be easy—

Mr McAllion: Could it have been overcome?

Mr Scaife: I said that we were aware of a £3 million problem in Perth and Kinross Healthcare NHS Trust and that the services from that trust were being split. Some of those services—at Perth royal infirmary—were going to the new university trust and some services were going to the primary care trust. We were actively involved with the managers of the trust and with the health board, who were putting together a recovery programme to ensure that they recovered their financial position. We agreed with them the exceptional use of capital receipts non-recurringly to bridge their progress towards financial recovery. Recurring moneys were also played in by the health board as part of that recovery programme and a package of efficiency savings was in place to deliver the rest of the programme.

Mr McAllion: But the acute trust asked for an additional £3 million over and above those measures so that it could have a balanced budget at the end of the year. The trust told you in April that that was the case.

Mr Scaife: It told us that there was a £3 million problem that had been inherited from Perth and Kinross Healthcare NHS Trust.

Mr McAllion: The trust knew that in February when it said that it could balance its books. What

changed between February and April when it said that it needed another £3 million to balance the books?

Mr Scaife: The recovery programme was put in place and non-recurring moneys were played in. The people on the ground were confident that that financial problem would be covered in that year and that thereafter they would achieve a recurring balance.

Mr McAllion: They could not have been confident of that or they would not have been asking you for £3 million. You mentioned financial hotspots across the NHS in Scotland. How many other trusts contacted you in April to say that they needed another £3 million of non-recurring allocation?

14:45

Mr Scaife: At that time, when many new trusts and teams were in place, many views were expressed across the country, mostly by the big acute trusts, which said that they faced significant financial problems. Trust chief executives were exchanging notes saying that they would have significant financial problems going into the next financial year.

Mr McAllion: In April 1999, how many trusts asked the department for an extra £3 million?

Mr Scaife: Other trusts did not ask the department.

Mr McAllion: Does that mean that it was only Tayside University Hospitals NHS Trust that did so?

Mr Scaife: Yes, it asked for an extra £3 million.

Mr McAllion: So, in April 1999, Tayside University Hospitals NHS Trust was the only trust to ask for money.

Mr Scaife: In a letter dated 14 April 1999, Sir William Stewart asked for a non-recurring £3 million. That was a consequence of the financial problem at Perth and Kinross Healthcare NHS Trust, which was well known and understood. A recovery programme had been put in place and non-recurring money was needed to bridge the gap.

Other NHS trusts were setting out their stalls to try to get the best financial deal. That is common budgetary practice in massive organisations.

Mr McAllion: Only one trust, Tayside University Hospitals NHS Trust, approached the department to ask for an extra £3 million, which was in addition to the amount in the financial recovery plan that had already been agreed with you. Did that approach not set the alarm bells ringing? Did that not encourage the department to do something special in relation to Tayside?

Mr Scaife: The request was for £3 million and was directly related to the problems at Perth and Kinross Healthcare NHS Trust.

Mr McAllion: Was that not already accounted for in the February financial recovery plan? Was the £3 million not over and above the sum provided for in that plan?

Mr Scaife: The request was made as a consequence of the financial problem in Perth and Kinross Healthcare NHS Trust, which was already known about and dealt with.

The Convener: I am loth to stop John McAllion, but Scott Barrie is leading on this section of the questions and Lloyd Quinan wants to get in.

Mr Quinan: My question is straightforward: do you believe that you had the staff, resources and budget to undertake properly the reorganisation of the national health service in Scotland?

Mr Scaife: Yes, I do.

Mr Quinan: Did you believe that then and do you believe that today?

Mr Scaife: Yes.

Mr Quinan: You believe that there was no requirement for further resources and for a larger budget to make the process smoother.

Mr Scaife: We had the resources that we needed to achieve a smooth transition from 47 NHS trusts to 28 NHS trusts and to achieve all the other targets that were set for us by ministers.

Mr Quinan: Do you believe that there was a smooth transition and that the structure is better financed than it was when you led the reorganisation?

Mr Scaife: Mr Quinan will see from the records that the system is better financed as there has been year-on-year, real-terms growth. It was a significant move in the right direction to create 28 NHS trusts out of the former internal market's 47 trusts. The Labour Government came to power in May 1997 and published "Designed to Care" in December 1997. We had a whole raft of targets to achieve between December 1997 and March 1999, including almost halving the number of trusts. All of that was achieved relatively smoothly.

Mr Quinan: What would you say to anyone who suggested that you were prepared to drive the reorganisation, irrespective of financial problems that you knew could arise? What would you say if they further suggested that you were simply responding to your job description and that you were planning to get out before things got difficult?

Mr Scaife: I would advise Mr Quinan that I was working under the direction of ministers. The

policy was clearly set out in the Labour party manifesto of May 1997: an incoming Labour Government would almost halve the number of NHS trusts and would achieve a 100,000 reduction in waiting lists and would meet various other targets. When Labour won the 1997 general election, it was for me and my team to advise ministers how to do that and what the consequences would be. I believe that the creation of the primary care trusts and local health care co-operatives and the structural and system changes that were brought into play were the right way in which to get health boards and trusts to work in partnership. The first real phase of changing the system was essentially about organisational change in the period leading up to March 1999.

Mr Quinan: So, for those people who would say that you were prepared to carry—

The Convener: I remind members that they should not stray into policy issues. Do you want to continue?

Mr Quinan: I made no policy statement. The only statements about policy that we heard came from Mr Scaife.

The Convener: Reminding us of our remit.

Mr Quinan: Yes. I find it somewhat illuminating that the policy statement came from Mr Scaife, not from me. I have a final question. Why did you leave the NHS in Scotland?

The Convener: With respect to Lloyd Quinan, we are getting a bit off the point. If you do not want to answer that question, you do not have to.

Mr Scaife: I leave it to your discretion, convener.

Mr Raffan: The chronology of the period that we are talking about is important. Much of the lack of clarity comes down to language, Mr Scaife. In your letter to the committee of 2 May, at the bottom of page 2, you state:

"Tayside was no different to any other region of Scotland, except that by halving the number of Trusts (from four to two) they should have had more scope than others to reduce their overhead costs".

Nevertheless, on page 3, you express your disappointment at the fact that

"almost from the inception of the new financial year, the Chairmen and others in the two new Trusts were signalling that all was not right with their finances."

In your view, Tayside had more room for manoeuvre in cutting costs and adapting to the new structure, yet there were still major problems in both trusts at the beginning of the new financial year. I would have thought that that would have set the alarm bells ringing doubly.

Mr Scaife: The restructuring in Tayside was no different from that in the rest of Scotland, as we moved from 47 trusts to 28. The point at the end of the letter, about the fact that there would no longer be four NHS trusts but two in Tayside, is relatively straightforward. If there were only two NHS trusts, there would not be a trust board, non-executive chairman or an executive team. A lot of overhead cost could be saved that would be available to be invested locally in the front line of patient care.

Mr Raffan: Yes, I follow all that. The point that I am making very simply—perhaps I was being too long-winded—is that, although you thought that Tayside was in a better situation than some other areas as a result of the halving of the number of trusts there, immediately at the beginning of the financial year the trusts were signalling that "all was not right". Later in the same paragraph, you say:

"Once the financial position became explicit in our monitoring".

I do not know whether it was implicit earlier. Clearly the signals were coming fast and furious, but there seems to have been a very slow reaction to the situation. A deadline for a recovery plan was set for the end of October, although you were already involved in correspondence in May and the chairmen had made their points in April. Things seem to have moved at a tortoise-like pace.

Mr Scaife: I have already explained that the financial issues of which we were aware related to Perth and Kinross Healthcare NHS Trust, and that a plan was in place—including non-recurring, bridging moneys—to ensure that the financial problem was resolved. That was of the order of £3 million. The chairman of Tayside University Hospitals NHS Trust raised that issue with me in April.

Throughout the period to which you refer, the returns from the trusts from the new financial year onwards indicated that they believed that they would achieve their financial targets. Not until 25 August did it become apparent that the trusts believed that they would not achieve their financial targets. It was then that we got in play to do everything that we could to ensure that those who were responsible locally in the NHS trusts and the health board put together a recovery plan to restore sound finances to the trusts and the health board in Tayside.

Scott Barrie: With the benefit of hindsight, do you think that the health department could have done more to ensure that the necessary financial information was available to the new health bodies on 1 April 1999?

Mr Scaife: There is not much more that we could have done in the lead-up to the creation of the new trusts in May 1999. We played in chief executives, finance directors and chairmen as

early as we could. We ensured that people were still around to sign off the old accounts. We put in support in the form of finance and administrative staff from the centre to work with finance directors and others to ensure that the accounts were properly closed down and that the accounting systems were robust. The financial outturn from 1998-99 was a good result the length and breadth of Scotland.

Scott Barrie: You feel that no more could have been done.

I will move on. We have already touched on the fact that the previous trusts in Tayside had achieved their financial targets only through the use of non-recurring funds. Will you clarify to what extent your department was aware that that was the practice in Tayside? Did you endorse that practice?

Mr Scaife: We were certainly closely involved in the resolving of the £3 million financial problem in Perth and Kinross Healthcare NHS Trust. We were fully aware of the requirement to use non-recurring moneys to bridge the trusts through the financial year so that the changes that they needed to bring about to secure a recurring balance were given time to be achieved. The department was fully aware of and approved that action.

It is not uncommon to use non-recurring moneys to bridge a trust from one year to the next when it is making significant service change. Service change takes time to pull off. It mainly concerns people; changing services is essentially about changing what staff do and it takes time to do that and for change to be managed.

It is important to ensure that, if non-recurring moneys are being used, there is the prospect of recurring moneys being available in due course so that the financial base is secure. We were satisfied that the instance referred to was a use of non-recurring moneys in a non-recurring way and we signed it off.

Scott Barrie: Will you give some indication of the length of time for which you expected the non-recurring moneys to continue to be used to achieve financial stability?

The Convener: You knew in 1997 that Perth and Kinross Healthcare NHS Trust was using such funds.

Mr Scaife: Traditionally, we would expect the non-recurring moneys to be used for one or two years. There are exceptions. For example, over the length and breadth of Scotland we have ceased to provide mental health services from large, isolated hospitals and built up community services in their place. Sometimes those programmes have taken four, five or six years and we have used non-recurring moneys to bridge the change.

Scott Barrie: So the department was satisfied that all was well with the use of non-recurring moneys in the previous trusts in Tayside.

Mr Scaife: Yes, we were.

The Convener: I want to establish the fact that several trusts, not only Perth and Kinross Healthcare NHS Trust, were using non-recurring moneys to balance their books in the transition year. Did you approve that?

Mr Scaife: I was referring to Perth and Kinross Healthcare NHS Trust, which had a sizeable problem and with which we were directly involved.

The Convener: Other trusts in Tayside were taking the same action, were they not?

Mr Scaife: We were not aware of that or of the extent of the problem until, eventually, in February 2000, the minister appointed a task force to work almost full-time trying to understand why the financial problem was so deep.

15:00

The Convener: But if it takes a task force to find out the extent of the financial problem, why on earth have a monitoring system? Surely that system was inadequate.

Mr Scaife: No. The monitoring system illustrated the problem and the size of the projected financial deficit. After we had allowed local management in both the trust and the health board to conduct its own inquiries, the task force worked almost full-time examining the books and establishing precisely what lay behind the financial overspend.

Scott Barrie: We have referred already to the recovery plan for Perth and Kinross Healthcare NHS Trust during 1998-99. We have also heard from the previous director of finance at Dundee Teaching Hospitals NHS Trust that a potential £9 million deficit in Tayside was identified in early September 1999. Given such problems, what steps did you take to ensure that the financial framework for Tayside for 1999-2000 was robust and that its financial targets would be met?

Mr Scaife: We were involved directly with the chairman and chief executives of the health board and the two trusts to ensure that they were seriously addressing the problems and that they were putting together a recovery plan. Two issues were involved: first, Tayside University Hospitals NHS Trust, where the major financial problem lay, had to understand that it had to get control so that the problem did not deteriorate. The trust had to understand why it had ended up in such a position.

The second issue centred around the health board and the extent to which it had a service strategy that would enable the people of Tayside to continue to enjoy a high-quality and accessible service, but one that was deliverable within the total resource that was available to the people of Tayside. You will know that the health board was engaged in an elaborate acute services review, which was examining services in Ninewells hospital, Perth royal infirmary, Stracathro hospital and in community hospitals. We were urging the health board to get on with that process and provide a clearer framework for the NHS trusts within which they would be able to balance their books.

I was directly involved in such work as were other senior colleagues. As I have explained, within two months of the problem being identified the minister was personally involved in meeting chairmen and so on.

Scott Barrie: Forgive me if I have slightly misunderstood you, Mr Scaife, but you seem to be suggesting that, when the extent of the financial problems came to light in September, it was very much a matter for Tayside Health Board and the two trusts to resolve. Was your department more proactive in helping it find solutions to the problem or was the problem regarded as a local difficulty for Tayside to resolve?

Mr Scaife: The matter was seen as an issue that needed to be resolved by the people working in Tayside. It was clear that service changes were needed and that those could be produced only by the people in Tayside who would need to consider carefully the consequences of any major service change. Tayside would have to consult locally. Our role was to offer advice and ensure that Tayside Health Board addressed the task seriously and got on with it quickly. We did not take the problem away from the people of Tayside and tell them what service or other changes were required. That was not our role.

Paul Martin (Glasgow Springburn) (Lab): Would I be correct in saying that the financial framework for Tayside relied partly on savings identified in the recovery plan for Perth and Kinross Healthcare NHS Trust, which could be achieved only as a result of the acute services review being completed?

Mr Scaife: I do not know in detail the extent to which the savings required from Perth and Kinross Healthcare NHS Trust were dependent on the outcome of the acute services review. I am aware that concern was expressed within Tayside University Hospitals NHS Trust that the acute services review that the health board was conducting was taking too long and would compromise the trust's achievement of its financial targets in 1999-2000.

Paul Martin: You were aware that the acute services review would be delayed and that the financial framework for Tayside relied partly on savings being identified in the recovery plan for Perth and Kinross Healthcare NHS Trust. Is that correct?

Mr Scaife: Yes.

Paul Martin: May I clarify that you were aware that the acute services review was delayed at that point?

Mr Scaife: I was aware that the acute services review in Tayside had a stop-start nature. There was an initial period when people were preoccupied with getting the process right and then there was the period in which the review got under way properly. We urged the health board to get on with it and to conclude its strategy. That does not mean that the trusts were powerless to act or that they could not do things to improve their financial position. All those concerned—the trusts, the health board and the health department—understood that long-term financial security for Tayside lay in getting on with the acute services review and implementing whatever decisions flowed from that process.

An important point is that it is for the people of Tayside to work out what services they require and what services they can afford. It would have been for the health board to consult the local people of Tayside about any significant changes in service. Had all not gone smoothly and had there been local objections to any proposals, it would have fallen to the minister to take the final decision. My role would have been to advise the minister. It was not my role to suggest which services were needed at Stracathro hospital nor to suggest that there was duplication of specific services at Perth royal infirmary and Ninewells hospital. It was my role to suggest that there was some duplication, but not to say what should be done about it.

Paul Martin: How did you expect savings to be made at Tayside Health Board to achieve a balanced budget when you knew that the acute services review was delayed? Alarm bells must have rung in the Scottish Executive. You must have known that Tayside Health Board would not be able to achieve its budget as a result of the acute services review being delayed.

Mr Scaife: I have explained that we became aware of the financial problem on 25 August 1999. Within two or three weeks of that, we played in directly. In less than two months, the minister was directly involved. We applied considerable pressure to the health board and the trusts to accelerate their processes in relation to the acute services review and the management action that needed to be taken operationally to ensure that

the financial problem did not worsen and was addressed. We escalated our involvement, ultimately bringing into play a ministerially appointed task force in February 2000.

The Convener: What duties or powers does the centre have to intervene when part of the financial problem comes from the over-provision of some services, as the Auditor General's report indicates happened in Tayside? That exacerbated the financial problem. Did you know about the over-provision of services and would you have had any powers to intervene, to advise an authority that it was over-providing?

Mr Scaife: We forcefully urged the health board and the trusts to get on and review acute services. With a population of 400,000 or so, a big teaching hospital in Dundee, an ex-wartime emergency medical service hospital at Stracathro and a busy and bustling hospital in Perth, which had Scotland's fastest-growing population, hospital stock was being maintained, in which services were duplicated. Of course we urged Tayside Health Board and other health boards to get on and review the disposition of services.

The Convener: That answer does not quite relate to the question I asked. The Auditor General's report points out that part of the problem was over-provision of services, funnily enough at Ninewells, not at Stracathro. You point in a different direction.

I will ask another question along those lines. Evidence shows that part of the financial problem was the fact that the number of patients coming across the Tay bridge from Fife into Tayside increased faster than the funding did. Mr Colville said:

"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 … The trend had built up over the three or four years up to 1998-99."—[*Official Report, Audit Committee,* 15 May 2001; c 664-65.]

Apparently, the authority asked you for assistance. Surely the people at the centre could have intervened to develop a disputes procedure or to help the bodies to obtain a sensible financial settlement. What are your powers of intervention? When would you choose to intervene? Why did nothing happen when the authorities brought a case to you regarding Fife?

Mr Scaife: You raise two issues. Nothing that I have said suggested that services ought to have moved out of Stracathro. I said that there were services in the big teaching hospital in Dundee, in Perth royal infirmary in Scotland's fastest-growing town and in Stracathro, which was a wartime emergency hospital. That is a lot of hospital stock. Delivering acute hospital services from three discrete sites for a population of 400,000 is bound to have financial consequences, particularly if duplication exists. That is all I said. We urged the health board to get on and review its acute services and to take some decisions, although it was acknowledged that those decisions would be difficult and very political, as we all know.

Your second point went back to Philip Colville's evidence. He was right to point to events that took place three or four years before 1998-99. At that time, we were in the height of the internal market. That was a different system, under which general practitioner fundholders existed and GPs had budgets to go shopping around for hospital care. It is true that GPs in north-east Fife often preferred to send their patients across the Tay bridge, rather than to hospitals in Fife. In the internal market, it was for GPs to decide where to send their patients and for NHS trusts to seek to recover the income from fundholders or health boards. The system was different. That system finally ended at the end of March 1999, when the changes to the "Working for Patients" proposals were fully implemented.

The Convener: But the centre did not intervene to stop a debit building up that contributed to the financial problems at that point.

Mr Scaife: Not in the days of the internal market—going back to the mid-1990s—when many fundholders sent patients to where they felt they would get the best service. It was a different system.

15:15

Paul Martin: You broadly touched on this point. We talked some minutes ago about the appointment of the task force. Given the wealth of experience in your former department and the wealth of experience of highly paid officials in a number of the trusts, were not you disappointed that various individuals were not able to deal with the matter before a task force was appointed?

Mr Scaife: The task force was appointed by the minister. Its remit was to work with people on the ground and to ensure that they were seeking to deliver quality services within the financial envelope that was available to them. That was part of the process of escalating our response.

We had been involved—we had been working with the health board and the trusts. The decision was taken that we should bring in an external team—some former NHS people and some from outside—to work with people on the ground to see whether they could turn the situation round. They were played in actively, almost on a full-time basis, over a period of months. Members will know that they produced their report in June. They will also know that around that time there were some

significant departures and the chairmen of Tayside Health Board and Tayside University Hospitals NHS Trust left. It was part of an orchestrated escalation of our involvement to ensure that there was a resolution of the financial problems in Tayside.

Paul Martin: On that point, the public could feel that a number of highly paid officials from various parts of the public sector let them down, because a task force was brought in at that point. Do you regret that that had to happen?

Mr Scaife: It was not done with regret; it was part of an escalation of our involvement. The task force was appointed by the minister to ensure that we got a result.

Mr Raffan: "Orchestrated escalation" is a lovely phrase, but the process seems to have been haphazard and slow, rather than planned. I do not want to sound like Perry Mason on a bad day, but the more I go through the chronology, the more I think that, with all the experience you had in your department and all the people on the ground, the orchestrated escalation was hellish slow.

You refer in your letter to "our monitoring". You seem to have depended totally on what you were told, because you did not have any of your men on the ground. I would like you to clarify that.

Mr Scaife: We did not have civil servants based in Tayside or elsewhere in the NHS. Rather, we expected the people who were employed by the NHS and who worked for health boards and NHS trusts to be able to manage their affairs locally. Our job as civil servants was to support ministers, to help them to develop policy, to monitor what was going on in the NHS on their behalf and to advise them, which is what we did.

Mr Raffan: This is a crucial point. I wish to pin you down and to get shorter and quicker answers. I do not mean to be rude, but it is important to do that, rather than to hear things repeated that we have already heard.

The fact is that in your letter of 2 May you say:

"Once the financial position became explicit in our monitoring".

Obviously, you were depending on the people on the ground. No one is saying that they were trying to mislead you intentionally, but with hindsight, would it have been better if you had had somebody there or if you had sent someone in a lot earlier than when the task force went in in February, when all the different alarm bells were ringing? It must have been a real cacophony by that stage, with so many bells going off in different places.

Should not you have sent somebody in? You talk about "our monitoring", but it was not really your monitoring. You were working on the basis of what others told you; you were not sending people in, despite all those alarm bells ringing, despite people saying that things were not as good as they were supposed to be and despite the fact that—to use that other wonderful phrase of yours—all was not right with the health board's and the trusts' finances.

Mr Scaife: You are right that we were monitoring the returns. NHS trusts and health boards are separate statutory bodies and are required to submit returns accurately. Our job was to monitor them; we did so. I have already explained that it was 25 August before the situation became clear. I have explained the process of escalation, when I became directly involved, the minister's personal involvement and the introduction of the task force. I have explained how we kept up the pressure to ensure that those who were responsible—in the health board and in the trust—turned around their finances and got on with their acute services review.

Mr McAllion: As you said before, it was August before you saw the July monitoring returns, which first indicated that there was a significant deficit. The Auditor General's report says that although the returns that came in showed that the rate-of-return targets had broken even, the accompanying commentary drew attention to the potential for a significant financial deficit. Did nobody pay any attention to the commentary that accompanied the returns?

Mr Scaife: I said in response to an earlier question that there was noise in the system, across a number of trusts, about how tight the finances were; that is not unusual. We monitored the trusts on the basis of the proper financial returns that they were required to submit—signed off by their finance directors—at the end of each month.

Mr McAllion: You also mentioned that there was an accountability meeting with officials from the trust and the health board in May. Is that right?

Mr Scaife: Yes.

Mr McAllion: Did nobody at that meeting draw the department's attention to the possibility of a significant deficit?

Mr Scaife: At that meeting, most of the discussion was about the need to conclude the acute services review and to have a sound financial plan for the whole of Tayside.

Mr McAllion: So, when the people on the ground indicated that they believed that a significant deficit problem was building up, the management of the NHS in Scotland did not believe them and thought that that was just "noise in the system"?

Mr Scaife: What I said was that there was always noise in the system—

Mr McAllion: Which you did not believe.

Mr Scaife: This time, the noise in the system was from across the country. But—

Mr McAllion: In Tayside, it was for real.

Mr Scaife: We monitored according to the financial returns that had been submitted by the trusts, as they were required to be.

The Convener: That noise was the biggest deficit in the country.

Shona Robison (North-East Scotland) (SNP): We are almost getting to the nub of the problem. You spoke earlier about local managers being expected to manage their affairs locally. Everybody would agree with that but, at the same time, we are exploring whether the procedures and the role of the centre were robust enough to pick up warning signals. From what you have said, I get the sense that they were not, because you did not expect things to go wrong and because things were expected to go smoothly and to be run properly locally. We may agree that that should have been the case, but you must surely have had a system in place in case things did not go smoothly.

What is now beginning to come out is that the system did not cope with things when they went wrong, because the system was not there to pick up on the alarm bells that clearly were ringing. Sitting here now and looking back on it, would not you acknowledge that that was the case? Otherwise, the system would have geared up and come into play long before it did.

Mr Scaife: I do not agree with that. I have explained that we were directly involved around the financial issues in Perth and Kinross. A recovery programme was in place and we had been working actively with people on the ground to ensure that it was carried out. The trusts and the health board gave us reassurances that a sound financial programme was in place. It was only when we got a different message from the formal monitoring that came in on 25 August that we realised that the financial problem was bigger than the one that we had been addressing. From that point on, we began to press even more—

Shona Robison: Is not the fact that the system did not pick up on the situation earlier part of the problem? It is almost as if you are sitting there saying that there are no lessons to be learned. Surely there are lessons to be learned about the monitoring role at the centre and its inability to pick up at an early stage what was happening locally. I find it quite frustrating that you sit there saying that there appear to be no lessons to be learned about a more robust monitoring role at the centre. If that is the case, we are saying that the situation could arise again.

Mr Scaife: I am saying that our monitoring of the problem throughout and our involvement with Perth and Kinross Healthcare NHS Trust, the health board and the other trusts in understanding and signing off the recovery programme for the £3 million put us in play, and that we were in play. We were bearing down quite firmly on the health board and on the trusts so that they would put in place a recovery programme. In earlier evidence, I said that Tayside was not unique in having significant financial problems. We were involved with other health boards and trusts across the country that managed to put in place recovery programmes and acute services strategies to secure financial balance. In Tayside, it took longer and was more difficult; in Tayside, the politics were very messy.

Shona Robison: What do you mean by that?

The Convener: Could you explain that?

Mr Scaife: I can explain it in terms of long-running discussions involving MPs and MSPs and changes in service.

Mr Quinan: There were no MSPs in March 1999.

The Convener: But there were MPs—some of them are here. So? That is the normal democratic process.

Mr Scaife: Of course.

The Convener: You are concentrating on the £3.3 million Perth and Kinross Healthcare NHS Trust deficit, but that is £3.3 million out of a £12 million deficit. Do you think that you missed something?

Mr Scaife: I am dealing with the sequence of events as they occurred.

The Convener: In August 1999, the deficit was £12 million for the whole of Tayside, of which the Perth and Kinross Healthcare NHS Trust deficit was £3.3 million. Did not your monitoring miss something?

Mr Scaife: I have explained that the size of the deficit became clear in August 1999. Before that, we were aware of the problem in Perth and Kinross Healthcare NHS Trust, where the deficit was nearer £3 million.

Mr Quinan: I want to refer back to an answer that you gave to Mr McAllion, who referred to the financial commentary that went along with the reports that you were receiving. You acknowledged that the commentary existed, but you gave the impression that no attention was paid to it. When you were in charge of the NHS in Scotland, was there a policy decision not to refer at all to financial commentaries and to look only at

the numbers that you were presented with?

Mr Scaife: No, of course not. We looked at all the information that came in. In earlier evidence, I explained not only that trust chief executives were talking about financial pressures, but that the chairman of the trust wrote about a financial issue—the £3 million problem that had been inherited from Perth and Kinross Healthcare NHS Trust. It was not apparent until 25 August that the financial problems were such that the trust would be unable to meet its financial duties.

Mr Quinan: If you had paid attention to the financial commentary that accompanied the reports, would not that have gone some way to answering the convener's question? You seem to be hiding behind the idea that, because people from all the trusts suggested that there were potential deficits, you should ignore them all. You are giving us the impression that you had a policy of ignoring anything that was not strictly on a balance sheet. I do not think that you were listening—do you want me to repeat that?

Mr Scaife: I was trying to pick up the point about the narrative.

Mr Quinan: I know. Do you want me to repeat my question?

Mr Scaife: Yes, please.

Mr Quinan: You give us the impression that you were prepared to look at the bottom-line figures and the bottom-line figures only. You acknowledge the existence of the financial commentary, but you appear to have paid no attention whatever to it. Can you explain that circumstance to us?

Mr Scaife: I do not have a copy of the narrative with me, but the first time that it suggested there was a financial problem, even though the numbers did not suggest that, was in the June return. That would have come in towards the end of July. We would have had perhaps four weeks in which to pick that up.

The Convener: We move on to consider whether the system of accountability governing the NHS in Scotland has been sufficiently clear and robust.

15:30

Margaret Jamieson (Kilmarnock and Loudoun) (Lab): In your letter of 2 May, you stated:

"With regard to finance and financial management, Chief executives and their executive teams in Health Boards and in NHS Trusts are accountable to their Boards for their management and operational performance."

The committee has received evidence from former chairs of Tayside health bodies, who suggested that their role was to determine the best health care for the people of Tayside and that financial matters were the responsibility solely of chief executives, who were accountable to the health department. Can you explain why the lines of accountability were unclear to those individuals?

Mr Scaife: I cannot explain why the former chairman of Tayside University Hospitals NHS Trust made the statement that he made: it was plainly wrong. The board and the trusts are responsible for ensuring that the residents of Tayside receive the best service that can be delivered to them within the budget that is allocated to the Tayside health service. This is not an either-or matter. There are no split lines of accountability.

Margaret Jamieson: We have seen some of the accountability reviews that you conducted with the health bodies in Tayside. Such reviews were the only vehicle through which you could speak to individuals to ensure that they were delivering on the priorities that the minister had set. How did you decide what other things were included on the agenda for accountability reviews? To what extent did financial performance and pressure feature in those reviews?

Mr Scaife: Accountability reviews were not the only vehicle through which we could discuss issues of significance with health boards or trusts. The reviews enabled us to sit down formally once a year with the health bodies to consider the whole spectrum of activity in the health system locally, to gauge the extent to which ministers' policies were being followed and to assess whether performance was up to the mark. Sometimes we also held interim reviews. Reference has been made to the routine monitoring that took place. There was not only financial monitoring, but monitoring of activity levels, how well people were delivering services and whether they were meeting waiting list targets and so on.

Margaret Jamieson: Would that process usually include the chairs of the health bodies?

Mr Scaife: Our monitoring of what was happening on the ground would, in the main, involve statistical returns. There was quite a lot of contact with chairs, chief executives and other members of the team. The contact involved ministers, and me and my team. People were drawn together regularly. There was a two-way exchange, so that ministers and ourselves could encourage people to deliver for their people locally and so that ministers and ourselves could get feedback about what was happening on the ground.

The Convener: Was there a system or was the contact ad hoc?

Mr Scaife: There were regular meetings.

The Convener: How regular?

Mr Scaife: Until May 1999, the convention was that there would be at least a quarterly meeting, involving all chairmen and the minister, at which I and colleagues would be present. There were also regular meetings with health board chief executives and trust chief executives. There were parallel regular meetings involving finance directors and other directors.

The Convener: What was the frequency of those regular meetings? Were they quarterly?

Mr Scaife: It varied. At one stage, there was a monthly meeting.

Margaret Jamieson: Are the minutes of those meetings available? I would be interested in those, because although you said today that you wanted to keep up the pressure and that you were working actively with people on the ground and bearing down on them, the accountability reviews make no reference to that on-going work to resolve the difficulties that people faced.

Mr Scaife: That is because the accountability review was an annual event. I have tried to explain the routine monitoring and contact.

Margaret Jamieson: The financial difficulty that led to this inquiry did not arise in one month; it developed over a period of time. I do not know whether you have had the opportunity to read some of the evidence that we have received. Chairs of trusts with significant public funds, who were part of the accountability review process, went ballistic if the financial report went beyond half a page of A4. Given the network of individuals within the health service in Scotland, I would have expected that information to reach your ears. That could have been chased up through the accountability review process.

Mr Scaife: I saw that reference in the *Official Report*. That is the first time that I had heard of it.

The Convener: Are minutes of those meetings available?

Mr Scaife: You would need to check with the department.

The Convener: Monitoring and regular contact sounds impressive, but I know that formal meetings of chairmen do not get down to detailed discussion of any one area. I have sat through plenty such meetings and know that the discussion tends to be general. If you want to know the nitty-gritty of what is going on in one area, you have to have a face-to-face meeting with the people involved, in their area. Monitoring sounds impressive, but if it involves only the gathering of statistics, it is not necessarily effective. Were the regular contacts and meetings effective?

Mr Scaife: I contend that they were very effective and that, throughout the NHS in Scotland, the committee will have seen outstanding performance by the health boards—

The Convener: Not in Tayside.

Mr Scaife: And by the NHS trusts. I have to set Tayside in the context of Scotland as a whole.

The Convener: But today we are considering Tayside, which has the worst record on finance in Scotland and one of the worst management records. That is what we are talking about. You were responsible for the NHS as a whole. You were the accounting officer. How did you monitor the developing situation and get to grips with it? Did you have the powers to do so? Did you take action? I am not sure that we are getting an answer. We have seen the result, but what was the department's part in it?

Mr Scaife: The department did not have powers to march into Tayside and dictate what service changes should happen in order for Tayside to balance its books.

The Convener: But did not the department have duties to monitor whether finances were being used appropriately or whether massive deficits were being built up?

Mr Scaife: We were monitoring that. As soon as we became aware of the problem, we acted and escalated our action so as to apply more pressure on those on the ground to come up with the goods. When that did not materialise to the minister's satisfaction, she appointed a task force.

Margaret Jamieson: Forgive me, Mr Scaife, but I would like to take you back. On your monitoring, were you looking at monthly or six weekly figures?

Mr Scaife: The financial reports came in monthly. Other reports came in—

Margaret Jamieson: How many weeks behind were they? Were they four weeks in arrears?

Mr Scaife: I have already explained that the financial report for July was received on 25 August. That would have been about the right time.

Margaret Jamieson: In terms of the work that you were asking of the chief executives and the chairs of the health bodies, did you direct them on how they could reduce the anticipated overspend by comparing costs—such as those that are contained within the blue book about comparators—or did you simply leave them to do that themselves?

Mr Scaife: The blue book, performance indicators and benchmarking statistics are the everyday stuff of managing health boards and NHS trusts. They were routinely available—

everybody used them. The problem was not that people in Tayside did not know that they had a relatively large number of hospital beds and it was not the fact that they enjoyed services that would not traditionally be available locally to populations of 400,000. The issues in Tayside were about reviewing the disposition of services and—with those who were working in the NHS in Tayside—proposing changes so that services could be delivered using the available money. That had to be done locally.

Margaret Jamieson: How, in that case, could you allow the trust to expand its cancer services? We heard from Sir William Stewart that the trust took the decision to appoint a new consultant, but forgot to have the structure that was required to support that consultant costed within the available funds. It is clear that individuals were running the health show in Tayside who were incompetent or who just wanted to do their own thing—irrespective of what you were trying to achieve by monitoring procedures.

Mr Scaife: We expected no NHS trust to seek to develop a highly expensive service, such as that which was produced following the arrival of Professor Rankin, without that trust being clear about the financial consequences of that and without its being confident that not only was the local health board aware of the cost, but that it was prepared and able to finance it from within its allocation. That is what health boards and trusts do the length and breadth of Scotland. New services emerge all the time and it is for health boards and trusts to anticipate the consequences of service developments, to plan for them and to ensure that the money is available.

Margaret Jamieson: I appreciate wholly what you are saying; however, the facts show that Tayside Health Board tried—irrespective of what you hoped it would do and of what was being done in the rest of Scotland—to do its own thing. That issue has never featured in any of the letters that we have seen following accountability reviews. I find it extremely strange that that significant expenditure was never agreed between the trust and the health board, and that you felt that you could just ignore that when you wrote to the chairs of the trust and the health board. You never drew that matter to their attention.

Mr Scaife: We were busy drawing to their attention the need to ensure that, within the total money that was available to them, they maintained existing services, financed any service expansion and met the costs of pay rises and everything else. That is what they exist to do locally. Obviously, there are competing pressures locally: the march of technology; the arrival of new drugs; and an aging population. All those factors cause people locally to want to expand and develop services. When running a health board or trust, one's job is to ensure that one can accommodate those pressures using the money that is made available by Government.

15:45

Margaret Jamieson: Some of my colleagues have referred to the financial difficulties that have been experienced over many years in Tayside—going back to the Lesley Barrie era—and it appears that we still have not got things right. The department really needs to consider effective root-and-branch treatment, because we do not seem to have emerged from that era. All services in Tayside have been affected, which is why this inquiry is now attracting so much attention from various groups.

The accountability review process could have identified difficulties. You pursued that system and had regular accountability review processes. However, we have received no information about follow-up accountability reviews or about any timetable that was provided to the services in Tayside to come forward with plans or actual savings. How could you monitor that, if you did not provide a timetable?

Mr Scaife: You will be aware from earlier evidence that a timetable was set for the production of a financial recovery plan. That was to be done by the end of October. It was produced by November 3 and followed up actively from then on. We did set timetables, we did follow up and we did ensure—once we were aware of the problem—that management action on the ground was taken.

The Convener: You said, "once we were aware of the problem". We shall be looking to the future, but do you think that the system was adequate, given that you were not aware of the problem earlier? You have explained about the transition but, given the history, I would have thought that warning bells would have been ringing and that close attention would be being paid to the organisation in Tayside—especially bearing in mind the reports that you were getting.

Mr Scaife: The history in relation to removal expenses, and the issues that were fully examined in the Kilshaw—

The Convener: The whole ethos of management, plus the use of capital for revenue spending—not just in Perth and Kinross, as far as I can see, but elsewhere—should surely have alerted the centre to a major problem that should have been investigated much more closely.

Mr Scaife: The Kilshaw report covered a separate set of issues, which were pursued vigorously. An inquiry team was put in place, and

the report was dealt with. I have explained the position in Perth and Kinross; I have explained that, provided that people were clear where recurring moneys were coming from, there was nothing intrinsically wrong—or, we judged that there was nothing intrinsically wrong—with people using non-recurring moneys to bridge a gap and to keep services going until there could be planned change.

I have also explained that Tayside was not unique in facing significant financial challenges. We were monitoring the country as a whole. We were involved with health boards and trusts elsewhere in Scotland in seeking to ensure that overspends were dealt with and that financial recovery programmes were put in place. In Tayside, that proved to be more difficult, but that was not the product of a weak monitoring system—the monitoring system worked. When we became aware of the problems in Tayside, we intervened, followed up, set deadlines, escalated our response, brought in a task force and progressively turned matters around.

There have also been changes in key personnel in Tayside. New leadership has arrived and the signs—from what I have read from evidence that the committee has taken—suggest that the situation has been grasped and is being turned around, which is all to the good.

The Convener: Tayside was not alone in having a deficit; however, it was alone in having a large deficit.

Mr McAllion: If the monitoring system works, can you explain how in a matter of months we went from a position in February 1999 in which the published financial framework balanced the books and met the costs of providing services throughout the region, to one in which we had a deficit that was spiralling out of control? Two years on, we have reached the point where 30 senior clinicians in Tayside are lining up to sign a letter that says that that the cuts in patient care that are required to make savings are unacceptable. That is not a working monitoring system; that is a system that has gone badly out of control—or which was not under control.

Mr Scaife: You are right to use the word "control" and to highlight the issue of financial control inside the NHS in Tayside. I am trying to explain clearly that our financial monitoring systems alerted us to the situation on 25 August, from which time we got into serious play.

Mr McAllion: Is not it the case that the financial framework that was published in February 1999 would have been realisable only if Tayside University Hospitals NHS Trust had moved away from its configuration of three hospitals throughout the region to a completely different pattern of services? When that did not happen, the trust and the management executive had no plan B to deal with the consequences of not implementing the acute services review. In fact, the situation spiralled out of control before the management executive realised what was happening, by which time it was too late for the executive to bring the situation back under control without affecting patient care.

Mr Scaife: I have already gone into detail about the extent to which Tayside University Hospitals NHS Trust, with its three hospitals, had too many beds—

Mr McAllion: It still has three hospitals.

Mr Scaife:—and duplications of service across the region. That was bound to be very expensive. People on the ground have known for a long time that they needed both to examine seriously and to rationalise acute services in Tayside. That has proved very difficult.

The Convener: I take it, in that case, that there was no plan B, as Mr McAllion said.

Mr Scaife: I assume that we are working on the premise that the available money is the available money. If the money cannot be found in Tayside to balance the books in the acute hospital sector from within that sector, money will have to be taken out of primary or community care. The decision that was taken locally was that primary care and community services in Tayside were not over-provided for or over-lavish, and that the savings were to be secured from the acute sector.

The Convener: The other option was to run a deficit.

Mr Scaife: No, the option was to get on and deal with the problem, to make decisions, to take people with us and to change services on the ground.

Mr McAllion: Does the health department accept any responsibility for what happened in Tayside? Are you going to blame it all on the local management? Do you think that you had any role in trying to secure patient services in an important part of Scotland?

Mr Scaife: Our responsibility was to ensure that the money that was available to Tayside was the right amount. As you know, money is allocated according to weighted populations and Tayside got its fair share of money. In a short time, Tayside University Hospitals NHS Trust experienced severe financial difficulties, partly because it was still addressing the problems that it had inherited from Perth and Kinross Healthcare NHS Trust. It was for the Tayside trust to sort out those problems within the context of an acute services strategy that was developed by the health board with the trusts' support. It was our job to ensure

that that was done, and that is what we set about doing.

The Convener: Tayside did not have its fair share of money. Am I correct in saying that Tayside received more than its population share? A reduction of that share would obviously have made its financial troubles even worse.

Mr Scaife: I stand corrected, convener; you are right. There was a very marginal overprovision of money against the area's theoretical capitation target.

The Convener: If you are in charge of the system, and you find out that an area that receives more than its proportionate share experiences financial troubles and must reduce services to solve the problem but does not do so, does not that give you a hint that an acute problem might arise? If you are at the centre and accountable to the Parliament and the Government, what do you do about that?

Mr Scaife: If a service change was proposed and was contested on the ground, the minister would have to make a decision. Health organisations locally should decide what service changes should be made and they should convince local people that a change is right for Tayside and they should consult on that. We in Edinburgh should not march into Dundee to tell people there which services they should change or stop, any more than we should march into Ayrshire or anywhere else and tell them what services to change or stop.

Mr McAllion: Time and again, we are told that the reason why we do not elect health boards or trusts is because they are directly accountable to the Parliament through the management executive and the minister. However, when we get management executive representatives to come to the Parliament they say, "Oh, it's not us; it's them." Somebody must be accountable for what went wrong; surely your department is accountable.

The Convener: Who is in charge overall?

Mr Scaife: The health board and trusts are accountable to the local population.

Margaret Jamieson: Dream on.

Mr McAllion: No—they are not; they are not elected.

The Convener: Continue if you would, Mr Scaife.

Mr Scaife: With respect, members all work hard to ensure that trusts and boards are accountable to the local population. They are accountable to the local population and to ministers for the delivery of services. They are also accountable to ministers for their performance, which is monitored through the Executive.

The Convener: The view from the centre must be different. With respect, I have never felt that Tayside health trusts and boards were accountable.

Mr Raffan: There is not much point in asking some of our questions. We seem merely to be going round in circles.

Mr Scaife, you are perfectly capable of marching into Dundee when you want to. The setting up of the task force and the sudden disappearance of the chairman of the health board are examples of that. Where there is a will, there is a way, is there not?

I will return to two matters that arise from the answers that you gave to Margaret Jamieson's questions, before I ask three other questions. The first matter is basic but important. The great D day, when you saw that blinding flash of light and all became apparent, was 25 August. Three weeks later on 15 September, you led a meeting to try to get things going. There were five formal meetings. The minister led one on 15 October and you led two—on 15 September and 15 February. The next day, the task force was sent in.

You say that you "got into serious play." You say that you escalated your involvement and response. However, you knew on 25 August that the situation was serious, but it seems that your involvement and response were not very hands on. You led only two of the meetings to which I referred. Although there was a deadline of the end of October for the recovery plan and it was received on 3 November—we know all that; I know it by heart now—you did not lead all those meetings; others led them. You led one meeting before the recovery plan was received and one only 24 hours before the task force was announced.

Who else was involved in dealing with the situation? Were you happy with the way that—that will be a silly question. Why was not more done more quickly?

Mr Scaife: A range of people from the management executive had regular and frequent contact with people in the health board and the NHS trusts from the performance management and finance sides.

Mr Raffan: I return to cancer services; they are important as a specific example of service development. We know from previous evidence that there was a feeling—a view would be a better way of putting it—in Tayside that cancer services there were not as good as those in other health board areas. Was there pressure on Tayside from the centre to do something about its cancer services, which resulted in the appointment of Professor Rankin and an upgrading of the local services?

Mr Scaife: There was no pressure from the centre to make specific appointments. Cancer care, as the committee knows, was one of three key service priorities for ministers. Coronary heart disease and mental health were the other two. There was therefore pressure on the system throughout the country to ensure that cancer services were as good as they could be.

Part of the problem for Tayside is that it is sandwiched between Aberdeen and Edinburgh and has a modest population of 400,000 that requires high-tech, expensive services. It has always been difficult for Tayside to stay up there with the big international hitters. Tayside is incredibly fortunate because, in relation to cancer in particular, it has a very strong university department and international players. Given that kind of quality in the university and the local ambition, it was not surprising that the trust recruited senior staff such as Professor Rankin.

16:00

Mr Raffan: We have heard a lot of evidence about the relatively high cost of health care in Tayside compared with other health board areas. You must have been aware of that through your monthly financial reports, accountability reports and one-to-ones with the chief executive and chairman.

Mr Scaife: Yes.

Mr Raffan: What did you do about it?

Mr Scaife: Over an extended period, we impressed on the health board the need to examine services and to review acute services in particular. We conducted a national review of acute services, led by Sir David Carter, which gave some pointers and we encouraged all the health boards, including Tayside Health Board, to rationalise their acute services—Tayside is not unique.

Mr Raffan: So you were aware of the situation over an extended period. Can you give an idea of the time scale in which you put pressure on the board and the trusts in relation to the relatively high cost of health care?

Mr Scaife: The process has been a continual one.

Mr Raffan: Although it became immediately apparent only on that black day—25 August. Given that you were responsible for holding Tayside health bodies to account, what do you consider caused the serious financial position that emerged in Tayside? We have heard mention of too many beds, duplication of services, a big property portfolio and service developments. I do not want to put words in your mouth and I realise that you have already responded to different questions, but perhaps you could bring it all together in one answer.

Mr Scaife: Many of the issues for Tayside flow from an attempt to deliver services on three acute hospital sites—Stracathro, Perth royal infirmary and Ninewells in Dundee. They also flow from an understandable ambition in Dundee, with its prestigious medical school, to have a full range of highly specialised services—with a resident population of roughly 400,000, that would always be difficult to sustain. In those circumstances, difficult choices have to be made.

Mr Raffan: In view of the fact that you were running acute services on three sites, what action did you take? I realise that I am in danger of asking you to repeat yourself. You were pointing out the duplication of the three sites and you knew that the review was on-going but was taking an awfully long time, so what did you do?

Mr Scaife: We encouraged people locally to review the balance of care that they were seeking to provide. In Tayside specifically, we encouraged them to review not only the acute hospitals and the range of services that they provided, but their ambitions for community hospital developments, which ran throughout the region, and to do that in a progressive way.

I emphasise that Tayside Health Board and the Tayside health system were not out of financial control until we became aware of it, in the first year of the Tayside University Hospitals NHS Trust. Reference has been made to travelling and removal expenses and of a specific culture in the health board, but that is not symptomatic of a health region that is out of financial control. So far as we were aware, Tayside Health Board and its constituent NHS trusts were able to deliver the services that they were trying to deliver within the allocation made available to them.

Mr Raffan: We have had a lot of evidence about the slow process of the acute services review in Tayside. That was one of the key factors. Did you try to accelerate that review from the centre? If so, how did you do it? Was it just through the accountability reviews and one-to-ones?

Mr Scaife: We discussed the need to get on with the acute services review with people in the health board and, to a lesser extent, with people in the trust. You will appreciate that this business is not straightforward. In Tayside, as in other teaching hospital regions, there is a complex set of interrelationships. Many senior clinicians play into that and there is a lot of politics in the region. The people on the ground tried to thread all that together into a coherent review process.

Mr Raffan: I do not want to go through the chronology yet again of the relationship between you, the board and the trusts and how the deficits

were dealt with. However, did you feel constrained in the way that you could hold the health board—indeed, any of the health bodies in Scotland—to account for what is a major part of the block? As I think the Auditor General has said, the block is roughly divided into thirds, one of which is for the NHS in Scotland.

Mr Scaife: It is always a challenge to make the books balance and to achieve all the targets.

Mr Raffan: That was not what I asked. I hesitate to interrupt you, but can we focus on whether you felt constrained in the way that you could hold the health bodies in Scotland to account?

Mr Scaife: Strained is the wrong word.

Mr Raffan: I said "constrained".

The Convener: Both might be appropriate.

Mr Scaife: That is why I reacted to the word.

I did not feel constrained in the sense that someone was saying, "You can't go there. You can't do that." As you know, there was a system—the internal market—with separate health boards and trusts, with trusts working in competition and with GP fundholders. From May 1997, there was an attempt to bring the pieces together to get the whole system working properly in partnership. That process of reform continues. As long as the minister is the final arbiter on contested service changes and people such as me are advising the minister, it is not for people such as me to go out into the field and tell health bodies what changes to bring about. That has to be decided and consulted on locally; if it is not, the minister is put in a position where he or she would be both judge and jury. That would be wrong.

Mr Raffan: I have a final, brief point. I do not want to sound like Michael Aspel on "This Is Your Life", but do you regret anything, Mr Scaife? When you look back, is there one thing that you would have done differently, such as performance monitoring or intervening earlier?

Mr Scaife: The central issue as far as I am concerned is the extent to which there was leadership on the ground to deliver the things that needed to be delivered: the acute services review and financial grip within the trust. That is what was needed and what we were pressing for, which is why we escalated things and brought in the task force.

The Convener: This market day is wearing late, but two other members wish to speak.

Mr Quinan: I have two matters to bring to your attention, Mr Scaife. You said that your primary function was to monitor the delivery of policy on behalf of the minister. If so, surely you would be required to operate within a clearly defined budget and budgetary terms. Which was of more importance: keeping within the budget or delivering the policy?

Mr Scaife: Keeping within the budget is part of delivering the policy.

Mr Quinan: I asked you a straightforward question. What was your primary function? Was it to keep within the budget or to delivery the policy?

Mr Scaife: The prime requirement is to deliver policy for ministers.

Mr Quinan: Thank you. I come now to my second question. You said that there was a need to encourage and rationalise the acute services review. It has been intimated to us that, during that period, it was suggested that, if Tayside were to take mould-breaking action in the cancer services area, such as the employment of a senior consultant, other finances would flow to it. Are you aware that that impression has been given to us? Do you accept that, to some degree, the action of employing a consultant without the support of services was a product of your forcing a policy agenda on people and suggesting that, if they met that policy agenda, they would receive the finance?

Mr Scaife: I do not accept the latter statement. It has always been the case that policy must be delivered within the resources available. That was clear to me, to the health board and to the NHS trusts. It is not an either-or situation. Services have to be delivered within the money available.

The Convener: Shona Robison wanted to ask a question.

Shona Robison: Keith Raffan asked the question that I was about to ask.

The Convener: Mr Scaife, you have had a long solo session. However, your evidence is important in providing a proper insight into the situation. If you wish to say anything further, I shall give you the opportunity to do so at the end of the meeting.

The committee should now turn its gaze to the present and future and to whether the improvements indicated in the Government's reforms under the health plan will prevent a repeat of the problems experienced in Tayside. We hope to find out when such improvements will be in place.

Paul Martin: Mr Jones, may I put you in the hot seat now? In earlier evidence to the committee, you talked at some length about the improvements in the system of accountability over the NHS. You referred particularly to expenditure and the implementation of the new health plan. Will you set out the key processes that will ensure that those improvements are achieved? What measures will be used to determine whether they have been achieved?

Mr Trevor Jones (Scottish Executive Health Department/Chief Executive of the National Health Service in Scotland): A range of measures is being implemented, the first of which are the new governance arrangements for the service under which the new NHS boards will be created. The boards will be in place by 30 September for the whole of Scotland. We have already appointed the chairs of the new boards in Tayside and in Fife, which are running a wee bit ahead of the timetable.

The new boards will increase the accountability of the NHS system. Local authority representatives will sit on the boards, which will enable the boards to be closer to the local populations. All key players in the NHS will be full corporate members, so accountability will be clear. There will be chairmen and chief executives of the whole system. We will have a single agenda and a single action plan for health and health care services in an area.

As I said, the new boards will be in place by 30 September. When I previously attended the Audit Committee, I described the new performance assessment framework, which is currently being put together. A meeting is taking place with NHS chief executives this afternoon at which departmental thinking about the framework will be shared. We intend to issue a document for consultation within the next three weeks or so, having first had some raw testing with key players. Our intention is that the performance assessment framework will operate from September. It will take time to build up momentum, but that will start as the new boards are created.

16:15

We are revising the financial framework in the NHS in order to make it simpler, to move away from some of the bureaucracy in the financial framework that was attached to the internal market and to address some of the issues that we have discussed today. For example, there will be a clear statement that each of the NHS boards will have a five-year financial plan that demonstrates that all its service developments can be met within the resources available. That was a key issue that we discussed today. The new financial framework will be introduced for the new financial year and so will operate from 1 April next year.

We are bringing in new planning arrangements for the NHS. We think that we need to strengthen how services are planned across the service, at the local health care co-operative level, at an NHS board level, at a regional level—that is, at the level of services that are provided by teaching hospitals—and nationally. We are also addressing the relationship between the health department and the service and are discussing that relationship with the service. Some lessons could be learned from our discussion this afternoon, and there is an issue about our getting even closer to the NHS in order to address some of the matters that have been discussed.

Paul Martin: That is a comprehensive package, but do you believe that it will prevent another Tayside or another £12 million deficit?

Mr Jones: I do not want to prolong the discussion, but I would like to explain why I think the problem became acute in Tayside before I answer that question.

The issue in Tayside was a breakdown in financial control, or a lack of financial control. That is what the task force said and it is also part of the Auditor General's report. The breakdown occurred relatively quickly, which is why we went from a position at 31 March of trusts—apart from Perth and Kinross Healthcare NHS Trust—being in balance to one by August in which deficits were identified. One cannot prevent the breakdown of financial control. One can have strong systems in place that set out the rules of how financial control should work and that pick up the breakdown of financial control, but it would be stupid of me to say that one can prevent the breakdown of financial control in an organisation. I would have to employ accountants to sit next to finance directors in every NHS board area, which would not be a sensible use of resources.

The measures that I described will strengthen significantly the accountability of the NHS in Scotland.

The Convener: You mentioned the five-year financial plan, but what assurances can you give us that monitoring will be better and more accurate than it has been in the past and that it will produce the goods?

In the old system, there were three boards and three sets of officials, yet the breakdown of financial control that you mentioned happened. In the new system, there is one board, but there are still three sets of officials, albeit that the chairmen and chief executives sit on the board. Can you guarantee that similar problems will not arise in the new system? What is being done to ensure that the control that we all want will be in place? We have come from a situation in which three boards and three sets of officials dealt with one another directly to one in which there is one board that deals somewhat more indirectly with three sets of officials.

Mr Jones: The starting point is that there will be a single chairman for the NHS system—the first person in the structure is the chairman of the NHS board. There will also be chairmen of trusts within that structure, but the primus inter pares will be the chairman of the NHS board. Therefore, there will

be a single point of contact between the department and the NHS system.

Members realise, I believe, that in constructing the new NHS for Scotland, we have worked within existing legislation, which requires us to have separate statutory organisations for trusts and for the new NHS board. In the health plan, we proposed a review, which we are about to commission, of the NHS management arrangements. As part of that review, we will consider whether the new governance arrangements that I have described work effectively or whether we need to tighten them further.

The Convener: I am concerned that the system broke down when there was direct accountability between the three boards and three sets of officials. I am looking for assurances that we will not face a similar set of problems when the system is slightly elongated.

Mr Jones: We are replacing health boards' existing health improvement programmes and individual trust implementation plans with a single health plan for the area. Within that health plan, there will have to be a single financial plan for the area. We will monitor jointly the performance of the whole system and we will expect a single report on the financial performance of an area. We will not monitor the organisations separately; we will monitor NHS Tayside.

The Convener: We wish you well in that.

Mr Raffan: I understand that you are unable to guarantee that financial control will not break down in the future, but can you please give us a guarantee that monitoring will improve? What we want, and what the people of Scotland and Tayside, within my regional constituency, want is a rapid reaction, which I do not think we had in this case. How can that be assured—by having somebody in the health board area, perhaps?

I accept the new structure and the new system, but what is crucial to me—this has come out partly in answers from Mr Scaife—is the relationship between boards. As you rightly said, the strain on a catchment area of 400,000 people of financing and supporting a major teaching hospital and the fact that people come from Fife and from the Forth valley—also within my regional constituency—mean that the integration of the workings of the three health board areas is crucial. I stress again the strain of having a major teaching hospital such as Ninewells, which is supported by a relatively small population base.

Mr Jones: I mentioned that we are revising the planning system and that we are considering how we should plan services regionally. That absolutely addresses the issue of cross-NHS-board boundaries. As part of the revised financial framework, we are reviewing how we fund specialist services. If one wanted to appoint an extra consultant for cancer in the Western general hospital in Edinburgh, for example, the approval of five NHS boards—or rather health boards, in Scotland—would have to be sought to fund the post. I do not believe that it is acceptable to appoint a consultant and seek funding and to require the agreement of five different health board areas. We need a simplified method of funding such specialist services. That needs to flow from the regional planning mechanism that we are devising.

The Convener: Can you give us an idea of the evidence that you will provide to show that your new system is working? What is the timetable?

Mr Jones: The test of the system will be to measure whether all the improvements and all the actions that we have set out in the health plan deliver the outcomes that we have promised. We are currently putting together detailed implementation proposals for all the actions in the health plan. We are also identifying what success looks like from the patient's perspective. We will monitor that rigorously over the next couple of years, which is the implementation timetable for the plan. Another test will be whether we have to sit having discussions like this in future.

Paul Martin: I wonder whether Mr Bates can answer a similar question about the key processes in ensuring improvements in governance and control in Tayside. When will the evidence that improvements have been implemented be available? It is really the same question, but in respect of Tayside health bodies.

Mr Peter Bates (NHS Tayside): The agenda is very challenging and will require a great deal of commitment and energy on the part of a number of people. It is my job to try to provide the focus for that commitment. As I have already told the Audit Committee, I will do that to the best of my abilities.

First, there is the immediate problem of getting the budget back in balance, to which Mr McAllion referred. That is clearly challenging. The acute services review process—the analysis—was completed and signed off within a few weeks of my assuming the chair. We have started the consultation process—the first consultation meeting took place in Arbroath last night. Another meeting is to be held this week and meetings will run throughout the coming months. We will then conclude.

To return to Mr Scaife's point, the challenge locally—properly, so I welcome this—will be to come to an understanding that we can provide services only within the money that we have. That will involve elected representatives, community activists and others. It will require difficult choices

to be made. It is my job to lead that process; if I do not, we will end up with another deficit and we cannot have that. Leading the process of recovery will be challenging.

I am extremely optimistic and positive about the unified board. I will have three senior elected representatives from three local authorities around the board table. They will represent clinicians and the important staff side, which we have not mentioned thus far.

Understandably, we have concentrated on Tayside's negatives, but I want to sing its praises. NHS Tayside is leading the way in Scotland in involving staff in partnership working. Partnership working is up and running and staff will sit around the board table. I feel a sense of real confidence that if I, with others, can help us through this challenging period of recovery, we will see a dynamic board in Tayside that will hold officials properly to account. When I last gave evidence, I said that accountability is crucial. I am optimistic and positive about that. As members can imagine, the immediate challenge is somewhat daunting, but it is my job to rise to that challenge.

Shona Robison: I agree with Mr Bates that it will be a real challenge to get the budget back into balance. The letter from clinicians that has been referred to shows that they feel that the budget reductions they are being asked to carry out will have a direct effect on patient care. They seem to operate in a parallel universe to the acute services review, where it is hoped, long-term savings are to be made. Will Mr Bates say whether he believes that to be the case and whether the budget reductions go in the same direction as the acute services review?

I want to ask Mr Jones to comment on a statement that he made in April when he gave evidence to the Audit Committee. He said that he would not countenance the quality of patient care being affected. About 30 clinicians have said that patient care will be affected. In the light of their comments, can Mr Jones continue to give the assurance he gave in April?

Mr Bates: The acute services review was complex, but it took too long. That created a vacuum. I am sad to say that in that vacuum a considerable climate of mistrust was generated in many communities. Some of the members here are very much in touch with that sense of mistrust. I regret that the review took too long and that, as a consequence, decisions that could or should have been made were not made. I cannot undo that process. I have to drive the acute services review process to its conclusion. I will do that with the Tayside community in an honest way. I will explain to its politicians, local and national, why we cannot continue to do everything that we are doing. In reaching our conclusions, I will seek the understanding and co-operation of the citizens of Tayside. We have to live within our means. That means making choices.

I have a great deal of sympathy with the clinicians—the doctors and nurses—and the staff who, understandably, are concerned that they face a continuing process of having to assist us to get the budget back in balance. However, as the chairman, I have a right to say to our senior clinicians that I need their leadership and co-operation; their capacity to think out of silos and to work together across boundaries; their commitment to work in different ways; their ability to have open minds; and their ability to work together—not separately—in acute and primary sectors so that we can find solutions.

Of course that is difficult. I have managed big organisations and I understand why people find that sort of challenge and change difficult. It is not my job to be so stupid or arrogant as to walk into hospitals and tell clinicians what they can and cannot do. That is not appropriate. As chairman, it is my job to bring consultants and other clinicians and groups of staff together and to tell them, "You must help me to find the solutions to the problems. You can't walk away and say that this is somebody else's problem. It is our problem. It cannot be solved by our saying that the minister must come in to solve it. We must solve it."

I understand the strength of feeling behind the article in today's edition of *The Courier and Advertiser*. Before it was run, I had committed myself to meeting consultants. I will always make myself available to meet staff, but they will have to respond to the challenge of helping me to get the budget back in balance. I hope that members of the Parliament and council members will understand that that will involve making difficult choices. We will not be able to continue to do all the things that we currently do.

Shona Robison: Mr Jones, you said that the quality of patient care would not be affected. Do you maintain that?

16:30

Mr Jones: I absolutely maintain that. We are now spending significantly more on the NHS than we have spent in the past. Health is receiving large increases in its budget. The health plan is about improving health services in a way that improves quality for the people receiving the services. We are moving away from the historic position of providing health services for the convenience of the provider. We are modernising the NHS—secondary and primary care—to make it much better for the people using it and to improve the quality of the service that we provide. That is our agenda.

There are choices that we must make and priorities that we must address. Peter Bates has talked about those. We must ensure that there is a fair distribution of health resources nationally and that in each area we have the right distribution of primary and secondary health care services. Our agenda is not to set in concrete the way in which we currently provide services. It is to review and improve services and to change how we do things. As we do that, we must ensure that quality improves. That is what I said in April and that is what I stress today. We cannot just stick with the status quo.

The Convener: I thank Trevor Jones and Peter Bates for that glimpse of how they see the future. Before I ask the Auditor General to speak, I offer Mr Scaife the chance of a last word.

Mr Scaife: No, thank you.

The Convener: I ask the Auditor General to comment on the proposals that Mr Jones and Mr Bates have made and to provide us with an indication of how he will monitor events, to ensure that the commitments that have been made are fulfilled.

Mr Robert Black (Auditor General for Scotland): Mr Jones gave a useful summary of what appears in a document known as the implementation programme for the national health plan. The document was published after the committee started to take evidence in the inquiry. It would be useful for members to acknowledge and take into account its existence when it formulates its report.

I am encouraged by the statements in the implementation programme about the arrangements that are planned to improve governance, performance management and financial control and accountability in the health service. The effectiveness of those new arrangements will depend in large measure on how they work through at a local level in health boards. It will be a significant step forward to have a unified financial plan and a single point of accountability, through the chair of the unified health board. However, we will still have a large teaching hospital that spends hundreds of millions of pounds of public money. There will still be a big spending organisation.

Understandably, much of this afternoon's discussion has centred on issues of financial control and on the committee's concern to be reassured that financial control will improve. The new systems that are planned will help in that regard. However, we must still ensure that within the unified health board the areas of big expenditure, such as the teaching hospital, manage their budgets well. I intend, on behalf of the Parliament and this committee, to continue to monitor developments and to use the audit process to report on how well the systems bed down over the next year or so. I will no doubt make further reports to the Parliament in due course.

The Convener: Thank you. We have just been given another glimpse of the future. The committee will now consider the evidence that it has taken and will report, but the matter will not end there. I am sure that the system will be monitored and that we will return to these matters at some point.

I thank our witnesses. We have had a long evidence-taking session, but this is a very important report. The committee appreciates your attendance and participation. I now formally end the public part of the meeting.

16:35

Meeting continued in private until 16:55.

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